

<b>Case Number:</b>	CM14-0134453		
<b>Date Assigned:</b>	08/27/2014	<b>Date of Injury:</b>	04/15/2011
<b>Decision Date:</b>	11/07/2014	<b>UR Denial Date:</b>	08/05/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/20/2014

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to an expert reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer is Board Certified in Neurological Surgery and is licensed to practice in California. He/she has been in active clinical practice for more than five years and is currently working at least 24 hours a week in active practice. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

According to the records made available for review, this is a 38-year-old male with an April 15, 2011 date of injury. At the time (7/3/14) of request for authorization for L4-5 Transforaminal Lumbar interbody fusion, there is documentation of subjective (low back pain and left buttock pain) and objective (marked paraspinal spasm, no tenderness to palpation in lumbar spine, lumbar flexion and extension limited, normal motor strength 5/5 in both lower extremities, sensory examination grossly normal in all dermatomes tested, patellar and Achilles reflexes 2+ bilaterally, and negative straight leg raise bilaterally) findings, imaging findings (Lumbar Spine Flexion/Extension X-rays (7/3/14) report revealed no instability; moderate degenerative findings in the lower aspects of the lumbar spine; MRI Lumbar Spine (5/1/14) report revealed at L4-5 mild loss of disc height and signal, stable posterior broad-based disc bulge, facet arthropathy and flavum hypertrophy result in moderate bilateral neural foraminal stenosis), current diagnoses (degeneration of lumbar or lumbosacral intervertebral disc), and treatment to date (epidural steroid injections, facet injection radiofrequency ablation, medications (including Norco, NSAIDs, and Gabapentin), physical therapy, and activity modifications). There is no documentation of severe and disabling lower leg symptoms and activity limitations due to radiating leg pain for more than one month or extreme progression of lower leg symptoms, objective signs of neural compromise, and an indication for fusion.

### IMR ISSUES, DECISIONS AND RATIONALES

The Final Determination was based on decisions for the disputed items/services set forth below:

**L4-5 Transforaminal Lumbar Interbody Fusion: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-308.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-307. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Discectomy/laminectomy and Fusion (spinal)

**Decision rationale:** The California MTUS reference to the ACOEM Practice Guidelines identifies documentation of severe and disabling lower leg symptoms in the distribution consistent with abnormalities on imaging studies (radiculopathy), preferably with accompanying objective signs of neural compromise; Activity limitations due to radiating leg pain for more than one month or extreme progression of lower leg symptoms; Failure of conservative treatment; and an Indication for fusion (instability OR a statement that decompression will create surgically induced instability), as criteria necessary to support the medical necessity of laminotomy/fusion. The Official Disability Guidelines identifies documentation of Symptoms/Findings which confirm presence of radiculopathy, objective findings that correlate with symptoms and imaging findings in concordance between radicular findings on radiologic evaluation and physical exam findings, as criteria necessary to support the medical necessity of decompression/laminotomy. Within the medical information available for review, there is documentation of a diagnosis of degeneration of lumbar or lumbosacral intervertebral disc. In addition, there is documentation of imaging findings (Lumbar Spine MRI identifying moderate bilateral neural foraminal stenosis at L4-5). Furthermore, there is documentation of failure of conservative treatment. However, there is no documentation of severe and disabling lower leg symptoms and activity limitations due to radiating leg pain for more than one month or extreme progression of lower leg symptoms. In addition, given documentation of objective findings (normal motor strength 5/5 in both lower extremities, sensory examination grossly normal in all dermatomes tested, patellar and Achilles reflexes 2+ bilaterally), there is no documentation of objective signs of neural compromise. Furthermore, given documentation of imaging findings (flexion/extension x-rays identifying no instability), there is no documentation of an Indication for fusion (instability OR a statement that decompression will create surgically induced instability). Therefore, based on guidelines and a review of the evidence, the request for L4-5 Transforaminal Lumbar interbody fusion is not medically necessary.

**Facility: Inpatient Stay (4-days):** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**MD Surgical Assistant:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**Pre-Op Visits:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**Pre-Op EKG:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**Pre-Op Labs: CBC with Platelets & DIFF, CMP, PTT, PT, UA with microscope:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**Post-Op Med: Percocet (10/325mg, #80):** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**Post-Op Med: Flexeril (10mg, #60):** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**Pre-Op Chest X-Ray:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.