

<b>Case Number:</b>	CM14-0090825		
<b>Date Assigned:</b>	07/25/2014	<b>Date of Injury:</b>	09/28/2010
<b>Decision Date:</b>	08/28/2014	<b>UR Denial Date:</b>	06/06/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/16/2014

### 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 Orthopedic surgery, and is licensed to practice in Texas. 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:

The injured worker is a 54-year-old female who reported an injury on 09/28/2010. The mechanism of injury was not provided for review. The injured worker reportedly sustained an injury to her low back. The injured worker's treatment history included physical therapy, activity modifications, medications, a home exercise program, and multiple Epidural Steroid Injections. The injured worker had persistent pain complaints, low back pain complaints that radiated into the bilateral lower extremities. The injured worker was evaluated on 05/19/2014. It was documented that the injured worker had on-going low back pain complaints. Physical findings included tenderness and spasms to palpation of the lumbar spine with limited range of motion secondary to pain and a negative straight-leg raising test. The injured worker had sensory loss over the dorsum of the left foot and base of the left foot. It was noted that the injured worker underwent an MRI of the lumbar spine on 05/09/2014 that indicated there was a 5 mm disc bulge with an annular tear causing left foraminal stenosis and nerve root compromise. The injured worker again was evaluated on 06/16/2014. It was documented that the injured worker's request for authorization for surgical intervention was not authorized due to a lack of psychological clearance.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**L5-S1 anterior fusion/ vascular approach anteriorly RFA 5-19-14 QTY: 1.00: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines:Low back (update 05/12/147Z)Spinal fusionIndications for surgery Discectomy.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 308-310.

**Decision rationale:** The requested L5-S1 anterior fusion/vascular approach anteriorly on 05/19/2014 is not medically necessary or appropriate. California Medical Treatment Utilization Schedule recommends fusion surgery for patients who have evidence of instability and persistent radicular complaints in dermatomal distributions consistent with pathology identified on an imaging study. The clinical documentation does indicate that the injured worker underwent an imaging study that identifies pathology that may benefit from surgical intervention. However, an independent evaluation of this imaging study was not provided for review. Furthermore, the American College of Environmental Medicine recommends psychological evaluation prior to spine surgery. The clinical documentation submitted for review does not provide any evidence that the injured worker has been psychologically evaluated and deemed an appropriate candidate for this type of invasive surgery. In the absence of this information, the appropriateness of surgery cannot be determined. As such, the requested L5-S1 anterior fusion/vascular approach anteriorly request for authorization 05/19/2014 quantity 1 is not medically necessary.

**L5-S1 posterior fusion w/ instrumentation RFA 5-15-14 QTY: 1.00:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines: Low back (updated 05/12/14)Fusion (spinal)Indications for surgery Discectomy.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-305.

**Decision rationale:** The requested L5-S1 posterior fusion with instrumentation on 05/19/2014 is not medically necessary or appropriate. California MTUS recommends fusion surgery for patients who have evidence of instability and persistent radicular complaints and dermatomal distributions consistent with pathology identified on an imaging study. The clinical documentation does indicate that the injured worker underwent an imaging study that identifies pathology that may benefit from surgical intervention. However, an independent evaluation of this imaging study was not provided for review. Furthermore, the ACOEM recommend psychological evaluation prior to spine surgery. The clinical documentation submitted for review does not provide any evidence that the injured worker has been psychologically evaluated and deemed an appropriate candidate for this type of invasive surgery. In the absence of this information, the appropriateness of surgery cannot be determined. As such, the requested L5-S1 posterior fusion with instrumentation request for authorization 05/19/2014 quantity 1 is not medically necessary.

**Allograft vs autograft report 5-19-14 QTY: 1.00:** 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.