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| <b>Case Number:</b>   | CM14-0183845 |                              |            |
| <b>Date Assigned:</b> | 11/10/2014   | <b>Date of Injury:</b>       | 03/08/2006 |
| <b>Decision Date:</b> | 03/04/2015   | <b>UR Denial Date:</b>       | 10/14/2014 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 11/04/2014 |

### 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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:  
 State(s) of Licensure: California  
 Certification(s)/Specialty: Orthopedic Surgery

### 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 66-year-old female with a reported date of injury of 03/08/2006. The mechanism of injury involved a fall. The current diagnoses include lumbar degenerative disc disease and lumbar herniated nucleus pulposus. The injured worker was evaluated on 08/24/2014 with complaints of 8/10 lower back pain with bilateral lower extremity radicular symptoms. It is noted that the injured worker has been previously treated with trigger point injections, facet injections, physical therapy, and medication management. The current medication regimen includes Norco, Xanax, Fioricet, and Imitrex. The physical examination revealed a slow and antalgic gait, diffuse tenderness to palpation of the cervical and lumbar spine, 20 degree flexion, 10 degree extension, less than 10 degrees of bilateral side bending, diffuse weakness in the lower extremities, and decreased sensation in the right dorsolateral and plantar foot. The treatment recommendations at that time included an L4-S1 TLIF decompression and fusion surgery. A Request for Authorization form was then submitted on 09/30/2014.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**L4-S1 Transforaminal Lumbar Interbody Fusion with Decompression: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-307.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-306. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, Fusion (spinal).

**Decision rationale:** California MTUS ACOEM Practice Guidelines state a referral for surgical consultation is indicated for patients who have severe and disabling lower extremities symptoms; activity limitation for more than 1 month; clear clinical, imaging, and electrophysiologic evidence of a lesion; and failure of conservative treatment. The Official Disability Guidelines state preoperative surgical indications for a spinal fusion should include the identification and treatment of all pain generators, the completion of all physical medicine and manual therapy interventions, documented instability upon CT scan or x-ray, spine pathology that is limited to 2 levels, and a psychosocial screening. There was no documentation of a psychosocial screening prior to the request for a lumbar fusion. There was no evidence of spinal instability upon flexion and extension view radiographs. Therefore, the injured worker does not meet criteria for the requested procedure. As such, the request is not medically appropriate at this time.

**Posterior non-segmental instrumentation:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

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

**Application of intervertebral biomechanical device:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

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

**Stereotactic computer assisted navigational procedure:** Upheld

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

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

**Autograft for spine surgery:** Upheld

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

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

**Allgraft moreselized or placement of osteopromotive material for spine surgery:** Upheld

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

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

**Medical clearance:** Upheld

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

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

**Pre-ops (unspecified):** Upheld

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

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