

<b>Case Number:</b>	CM15-0106463		
<b>Date Assigned:</b>	06/12/2015	<b>Date of Injury:</b>	05/09/1993
<b>Decision Date:</b>	08/05/2015	<b>UR Denial Date:</b>	05/28/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/02/2015

### 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: New York

Certification(s)/Specialty: Neurological 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 44 year old male with an industrial injury dated 05/09/1993. The mechanism of injury is documented as lifting when he began to experience sharp aching pain in his lower back. Diagnoses included acquired spinal stenosis due to combination of spinal canal degenerative herniated disc with significant compression of the nerve root at lumbar 5- sacral 1 and low back pain with right lower limb radiculopathy. Prior treatment included physical therapy, two pain injections to his low back, epidural steroid injection (no relief) and medication. He presents on 04/16/2015 with complaints of low back pain rated as 9/10. The pain is characterized as a sharp/stabbing, aching and sharp sensation that radiates down both legs to the feet. Physical exam of the thoraco lumbosacral spine showed tenderness over the lumbar spine with sciatic notch tenderness. Range of motion was limited and painful. There was decreased sensation over the posterolateral thigh and calf and dorsolateral plantar lateral surface of the right foot. MRI of lumbar spine dated 04/02/2015 report is documented in the 04/16/2015 note showing degenerative disc with mild bulging at lumbar 3-4 and lumbar 4-5 with significant marked narrowing disc space and herniation extrusion disc noted at lumbar 5-sacral 1. The complete report is in this note. There is not a formal report in the submitted records. Treatment plan was for decompression laminectomy/discectomy with fusion of lumbar 5-sacral 1 with posterior segmental instrumentation and transforaminal interbody fusion cage with associated surgical services. The requested treatments are decompression fusion lumbar 5-sacral 1 with posterior segmental instrumentation with transforaminal lumbar interbody fusion (TLIF) and cage, associated surgical services to include assistant surgeon, hospital admit 3 days and pre-

operative surgical clearance. The request for elevated toilet commode (bilateral low back area), front wheel walker is not listed on the application.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

#### **Decompression fusion L5-S1 with posterior segmental instrumentation with transforaminal lumbar interbody fusion (TLIF) and cage: 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): 305-7.

**Decision rationale:** The California MTUS guidelines do recommend a spinal fusion for traumatic vertebral fracture, dislocation and instability. This patient has not had any of these events. The guidelines note that the efficacy of fusion in the absence of instability has not been proven. The requested treatment: Decompression fusion L5-S1 with posterior segmental instrumentation with transforaminal lumbar interbody fusion (TLIF) and cage is not medically necessary and appropriate

**Pre-operative surgical clearance:** 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.

**Associated surgical service: assistant surgeon:** 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.

**Associated surgical service: hospital admit 3 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.