

<b>Case Number:</b>	CM15-0186866		
<b>Date Assigned:</b>	10/01/2015	<b>Date of Injury:</b>	04/28/2013
<b>Decision Date:</b>	11/23/2015	<b>UR Denial Date:</b>	09/09/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/22/2015

### 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, Montana, California  
 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 51 year old female who sustained an industrial injury on April 28, 2013. A preliminary report dated August 03, 2015 reported "failed to improve with all types of physiotherapy, epidural injections, medications, and rest." She "wishes to consider surgical treatment." There are noted subjective complaint of: "these happened suddenly; they are feeling wore over time." "Moderate to severe at worse 9 in intensity," "It is constant." "Primarily 70% in the back, 30% in the left leg." "It radiates down the left side." The plan of care is with recommendation for surgical intervention, left L4-S1 TLIF decompression. A neurological evaluation dated August 04, 2014 reported interim history of: "patient is severely depressed with constant stabbing low back pain rated a 10 in intensity shooting to hips, cramping in legs, intermittent claudication in calves, numbness, tingling in feet and toes, difficulty walking severe constant neck pain shooting to shoulders." The following diagnoses were applied to this visit: multiple disc disease, radiculopathy, myelopathy; abnormal gait, difficulty walking, intermittent claudication, chronic low back pain, and depression. The plan of care is with recommendation for: MRI of spine, orthopedic consultation for surgical intervention, and prescribed: soma, Skelaxin, Oxycodone, Lyrica, and Cymbalta. On August 31, 2015 a request was made for surgery in the form of L4-S1 TFAL, 3 day inpatient stay, preoperative clearance that was noncertified by Utilization review on September 09, 2015.

### 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 Decompression and Fusion: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Low Back Complaints 2004, Section(s): Surgical Considerations.

**Decision rationale:** California MTUS guidelines do recommend spinal fusion for fracture, dislocation and instability. Documentation does not provide evidence of this. Her magnetic resonance imaging scan (MRI) showed no severe canal or foraminal stenosis. Her provider recommends a transforaminal interbody lumbar arthrodesis with decompression to treat her lumbago. Documentation does not present evidence of instability. The MRI with flexion and extension of 5/19/14 did not report this. According to the Guidelines for the performance of fusion procedures for degenerative diseases of the lumbar spine, published by the joint section of the American Association of Neurological surgeons and Congress of Neurological surgeons in 2005 there was no convincing medical evidence to support the routine use of lumbar fusion at the time of primary lumbar disc excision. This recommendation was not changed in the update of 2014. The update did note that fusion might be an option if there is evidence of spinal instability, chronic low back pain and severe degenerative changes. Documentation does not show instability or severe degenerative changes. The requested treatment: L4-S1 Transforaminal Lumbar Interbody Decompression and Fusion is not medically necessary and appropriate.

**Associated Surgical Service: 3 day Inpatient Stay: 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:** As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.

**Pre-operative CBC: 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:** As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.

**Pre-operative CMP: 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:** As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.

**Pre-operative PT/PTT:** 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:** As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.

**Pre-operative 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:** As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.

**Pre-operative Urinalysis:** 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:** As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.

**Pre-operative 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:** As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.

**Associated Surgical Service: Medical Clearance from Internal Medicine Doctor:** 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:** As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.