

<b>Case Number:</b>	CM15-0025431		
<b>Date Assigned:</b>	02/17/2015	<b>Date of Injury:</b>	07/11/2013
<b>Decision Date:</b>	04/17/2015	<b>UR Denial Date:</b>	01/14/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/10/2015

### 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: California

Certification(s)/Specialty: Pediatrics, 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 61-year-old female with a reported date of injury of 07/11/2013. The mechanism of injury involved heavy lifting. The current diagnoses include lumbar stenosis, neurogenic claudication symptoms, lumbar spondylolisthesis, and lumbar disc displacement. The injured worker presented on 12/19/2014 for a consultation regarding low back pain. The injured worker reported chronic low back pain with lower extremity numbness and weakness. The injured worker had several lumbar injections as well as physical therapy. Upon examination, there was 3/5 motor weakness, diminished perception of light touch in the bilateral shin and lateral foot area, 2+ deep tendon reflexes, absent clonus and Hoffman's, an inability to toe and heel walk due to lower extremity numbness and weakness, moderate to severe tenderness to palpation of the mid lumbar spine, normal range of motion, and negative straight leg raise. Recommendations at this time included an L4-5 decompression and facetectomy with discectomy and fusion. It is noted that the injured worker underwent an MRI of the lumbar spine on 06/27/2014, which revealed evidence of moderate loss of disc height at L4-5 with grade 1 anterolisthesis, moderate bilateral neural foraminal narrowing, and encroachment on the bilateral L5 nerve roots in the lateral recesses. The injured worker also underwent flexion and extension view x-rays on 06/27/2014, which revealed 0.8 cm of anterolisthesis of L4 on L5. There was no Request for Authorization submitted for this review.

## IMR ISSUES, DECISIONS AND RATIONALES

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

### **Transforaminal Lumbar Interbody Fusion L4-5: 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): 305-306.

**Decision rationale:** The California MTUS/ACOEM Practice Guidelines state a referral for surgical consultation is indicated for patients who have severe and disabling lower extremity symptoms; activity limitations for more than 1 month; clear clinical, imaging, and electrophysiological evidence of a lesion; and a 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 x-ray or CT myelogram, spine pathology that is limited to 2 levels, and a psychosocial screening. While it is noted that the injured worker has positive examination findings as well as imaging findings, there is no documentation of an exhaustion of recent conservative treatment to include active rehabilitation. There was also no documentation of a psychosocial screening completed prior to the request for a lumbar fusion. Given the above, the request is not medically appropriate at this time.

### **Associated Surgical Service Inpatient Length of Stay (LOS) x3 days: Upheld**

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

**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 Surgery Assistant- PA (Physician Assistant): Upheld**

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

**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- Operative DME purchase: Aspen LSO Lumbar Brace: Upheld**

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

**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.