

<b>Case Number:</b>	CM14-0118597		
<b>Date Assigned:</b>	09/23/2014	<b>Date of Injury:</b>	02/16/2002
<b>Decision Date:</b>	10/28/2014	<b>UR Denial Date:</b>	07/10/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/28/2014

### 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 Spine Surgeon 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 male who reported an injury on 02/16/2002. The mechanism of injury involved a fall. It is noted that the injured worker is status post microdiscectomy in 2002. Previous conservative treatment also includes epidural steroid injections, physical therapy, facet injections, and medication management. The injured worker was evaluated on 06/20/2014 with complaints of persistent lower back pain radiating into the left lower extremity. Physical examination revealed normal motor strength in the bilateral lower extremities with positive straight leg raising on the left. Treatment recommendations at that time included an anterior-posterior fusion at L4-5 and L5-S1. A Request for Authorization form was then submitted on 06/23/2014. It is noted that the injured worker underwent an MRI of the lumbar spine on 04/09/2013, which indicated disc desiccation and disc bulging at L3-4, with mild bilateral neural foraminal narrowing, 3 mm broad based disc protrusion at L4-5 with moderate bilateral neural foraminal narrowing, and disc desiccation at L5-S1 with mild left neural foraminal narrowing.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**L4/5, L5/S1 anterior posterior lumbar spine instrumented:** Upheld

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

**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 extremity 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 x-ray of CT myelogram, spine pathology that is limited to 2 levels, and a psychosocial screening. As per the documentation submitted, the patient's physical examination only revealed positive straight leg raising. There was no documentation of a significant functional limitation. There was also no documentation of spinal instability upon flexion and extension view radiographs. There was no mention of a psychosocial screening prior to the request for a lumbar fusion. As such, the request is not medically appropriate at this time.

**Vascular 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.

**1 Pre Operative, History and Physical, Labs, EKG, chest X-ray:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines Low Back - Lumbar & Thoracic (Acute & Chronic)

**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.