

<b>Case Number:</b>	CM14-0160671		
<b>Date Assigned:</b>	10/06/2014	<b>Date of Injury:</b>	07/19/2013
<b>Decision Date:</b>	10/30/2014	<b>UR Denial Date:</b>	09/24/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/30/2014

### 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 Surgery, has a subspecialty in Spine Surgery, and is licensed to practice in California. 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:

According to the records made available for review, this claimant is a 41-year-old female with a 7/19/13 date of injury. At the time (9/9/14) of request for authorization for Transforaminal lumbar interbody fusion at the L5-S1 level with posterior instrumentation and bone grafting, assistant surgeon, Pre-operative evaluation, and Facility: Inpatient x3 days, there is documentation of subjective (low back pain radiating to the right lower extremity and into the foot with numbness, tingling, and weakness) and objective (spasms, tenderness and guarding in the paravertebral muscles of the lumbar spine, decreased strength of the knees and ankles, and decreased sensation in the L5 and S1 dermatomes) findings, imaging findings (reported MRI of the lumbar spine (12/23/13) revealed 5 mm posterior disc protrusion with moderate lateral recess stenosis bilaterally at L5-S1; report not available for review), current diagnoses (lumbosacral radiculopathy), and treatment to date (medications, physical modalities, and activity modification). 9/8/14 medical report identifies that the requesting physician is retracting his request for lumbar arthrodesis at L5-S1 as the patient remains hesitant about the operation. There is no documentation of an imaging report and an indication for fusion (instability OR a statement that decompression will create surgically induced instability).

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Transforaminal lumbar interbody fusion at the L5-S1 level with posterior instrumentation and bone grafting:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-307. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back - Fusion

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-307. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, Discectomy/laminectomy and Fusion (spinal)

**Decision rationale:** MTUS reference to ACOEM identifies documentation of severe and disabling lower leg symptoms in the distribution consistent with abnormalities on imaging studies (radiculopathy), preferably with accompanying objective signs of neural compromise; activity limitations due to radiating leg pain for more than one month or extreme progression of lower leg symptoms; failure of conservative treatment; and an indication for fusion (instability OR a statement that decompression will create surgically induced instability), as criteria necessary to support the medical necessity of laminotomy/fusion. ODG identifies documentation of subjective (pain, numbness, or tingling in a correlating nerve root distribution) and objective (sensory changes, motor changes, or reflex changes (if reflex relevant to the associated level) in a correlating nerve root distribution) radicular findings in each of the requested nerve root distributions, imaging (MRI, CT, myelography, or CT myelography & x-ray) findings (nerve root compression OR moderate or greater central canal stenosis, lateral recess stenosis, or neural foraminal stenosis) at each of the requested levels, and failure of conservative treatment (activity modification, medications, and physical modalities); as criteria necessary to support the medical necessity of decompression/laminotomy. Within the medical information available for review, there is documentation of a diagnosis of lumbar radiculopathy. In addition, there is documentation of subjective (pain, numbness, and tingling) and objective (sensory and motor changes) radicular findings the requested nerve root distribution, and failure of conservative treatment (activity modification, medications, and physical modalities). However, despite the 7/21/14 medical report's reference to imaging findings (MRI of the lumbar spine identifying 5 mm posterior disc protrusion with moderate lateral recess stenosis bilaterally at L5-S1), there is no imaging report included in the documentation submitted. In addition, there is no documentation of an indication for fusion (instability OR a statement that decompression will create surgically induced instability). Furthermore, given documentation that the requesting physician is retracting his request for lumbar arthrodesis at L5-S1 as the patient remains hesitant about the operation, there is no documentation of the medical necessity for the requested Transforaminal lumbar interbody fusion at the L5-S1 level with posterior instrumentation and bone grafting. Therefore, based on guidelines and a review of the evidence, the request for Transforaminal lumbar interbody fusion at the L5-S1 level with posterior instrumentation and bone grafting is not medically necessary.

**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.

**Pre-operative evaluation:** 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.

**Facility: Inpatient x3 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.