

<b>Case Number:</b>	CM15-0111408		
<b>Date Assigned:</b>	06/11/2015	<b>Date of Injury:</b>	11/12/2002
<b>Decision Date:</b>	07/14/2015	<b>UR Denial Date:</b>	05/27/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/09/2015

### 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 46 year old female, who sustained an industrial injury on 11/12/2002. Medical records provided by the treating physician did not indicate the injured worker's mechanism of injury. The injured worker was diagnosed as having shoulder impingement, knee tendinitis/bursitis, lumbosacral radiculopathy, and generalized pain. Treatment and diagnostic studies to date has included placement of a spinal cord stimulator, physical therapy, epidural injections, home exercise program, medication regimen, magnetic resonance imaging of the lumbar spine of an unknown date, removal of spinal cord stimulator, and status post left knee arthroplasty. In a progress note dated 05/06/2015 the treating physician reports complaints of continued back, knee, and leg pain. The leg pain is noted to be bilateral with the worse on the left side. Examination reveals spasm and tenderness to the lumbar paravertebral muscles, loss of range of motion to the lumbar spine, dysesthesia over the left lumbar five and the left sacral one level, dysesthesia over the right sacral one level, diminished patellar reflexes on the left side, and decreased ankle Achilles tendon reflexes on the right side. The treating physician noted an magnetic resonance imaging of an unknown date that was revealing for desiccation at multiple levels, an annular tear at lumbar four to five and at lumbar five to sacral one, disc bulge, severe lateral recess stenosis at lumbar five to sacral one, facet hypertrophy, and significant foraminal stenosis bilaterally. The treating physician requested a transforaminal lumbar interbody fusion at lumbar four to five and lumbar five to sacral one with instrumentation and bone grafting with the treating physician requesting this procedure due to the above listed findings. Along with the

requested surgical procedure the treating physician requested an assistant surgeon, two units of autologous blood donation, a three day hospital stay, and a lumbar brace.

### **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 and L5-S1 instrumentation and Bone Grafting: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Treatment in Workers Compensation, Online Edition, Chapter: Low Back, Fusion (spinal).

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-307.

**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: Transforaminal Lumbar Interbody Fusion L4-5 and L5-S1 instrumentation and Bone Grafting is not medically necessary and appropriate.

**Associated surgical services: 3 Day Hospital 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:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**Associated surgical services: 2 Units of Autologous Blood Donation: 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 services: 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 services: Lumbar Brace:** 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.