

<b>Case Number:</b>	CM14-0141530		
<b>Date Assigned:</b>	09/19/2014	<b>Date of Injury:</b>	05/09/1993
<b>Decision Date:</b>	11/20/2014	<b>UR Denial Date:</b>	07/31/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/02/2014

### 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 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 is a 42-year-old male with a 5/9/93 date of injury. At the time (4/28/14) of request for authorization for Staged L5-S1 Anterior Lumbar Decompression with interbody fusion followed by posterior bilateral foraminotomy, facetectomies and posterior fixation, Front wheel walker, 3:1 Commode, Cold therapy, Back brace, Co-Surgeon, 3 days inpatient stay for anterior, and 3 days inpatient stay for posterior, there is documentation of subjective (low back pain radiating to bilateral lower extremities and posterior left leg tightness/spasms) and objective (tenderness to palpation over lumbosacral region with decreased range of motion) findings, imaging findings (reported MRI lumbar spine (date unspecified) revealed L5-S1 disc desiccation; report not available for review), current diagnoses (L5-S1 disc degeneration and L3-4/L4-5 disc desiccation/annular tears), and treatment to date (medications, home exercise program, physical therapy, and chiropractic treatments). There is no documentation of objective findings which confirm presence of radiculopathy; activity limitations due to radiating leg pain for more than one month or extreme progression of lower leg symptoms; an indication for fusion (instability or a statement that decompression will create surgically induced instability); and an imaging report.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Staged L5-S1 Anterior Lumbar Decompression with interbody fusion followed by posterior bilateral foraminotomy, facetectomies and posterior fixation: 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 Chapter, Spinal 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 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 Symptoms/Findings which confirm presence of radiculopathy, objective findings that correlate with symptoms and imaging findings in concordance between radicular findings on radiologic evaluation and physical exam findings, as criteria necessary to support the medical necessity of decompression/laminotomy. Within the medical information available for review, there is documentation of diagnoses of L5-S1 disc degeneration and L3-4/L4-5 disc desiccation/annular tears. In addition, given documentation of subjective (low back pain radiating to bilateral lower extremities and posterior left leg tightness/spasms) findings, there is documentation of lower leg symptoms which confirm presence of radiculopathy. Furthermore, there is documentation of failure of conservative treatment. However, despite non-specific documentation of objective (tenderness to palpation over lumbosacral region with decreased range of motion) findings, there is no specific (to a nerve root distribution) documentation of objective findings which confirm presence of radiculopathy. In addition, there is no documentation of activity limitations due to radiating leg pain for more than one month or extreme progression of lower leg symptoms; and an indication for fusion (instability or a statement that decompression will create surgically induced instability). Furthermore, despite documentation of medical report's reported imaging findings (MRI of lumbar spine identifying L5-S1 disc desiccation), there is no documentation of an imaging report. Therefore, based on guidelines and a review of the evidence, the request for Staged L5-S1 Anterior Lumbar Decompression with interbody fusion followed by posterior bilateral foraminotomy, facetectomies and posterior fixation is not medically necessary.

**Front wheel walker:** 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.

**3:1 Commode: 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.

**Cold therapy: 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.

**Back 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.

**Co-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.

**3 days inpatient stay for anterior: 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.

**3 days inpatient stay for posterior:** 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.