

<b>Case Number:</b>	CM13-0009135		
<b>Date Assigned:</b>	12/27/2013	<b>Date of Injury:</b>	08/01/2011
<b>Decision Date:</b>	02/27/2014	<b>UR Denial Date:</b>	08/09/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/09/2013

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Orthopedic Surgery, has a subspecialty in Spine Fellowship 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 physician 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 45-year-old male patient, with an 8/21/12 date of injury. At the time of request for authorization for lumbar fusion, hospital stay, anti-embolism stocking, and Cybertech back brace, there is documentation of subjective (low back pain that radiates to the buttocks, lateral thighs, and calves associated with numbness in the calves and feet) and objective (moderately restricted lumbar spine range of motion and decreased light touch sensation in the lateral calves) findings, imaging findings (MRI lumbosacral (5/11/13) report revealed diffuse bulging of the annulus in combination with minimal facet hypertrophy at L3-4 which mildly flatten the anterior thecal sac without canal stenosis or focal nerve root impingement as well as disc bulge extending into the neural foramina slightly narrowing the neural foramina bilaterally; mild facet hypertrophy at L4-5 without canal or foraminal stenosis), current diagnoses (lumbar strain, thoracolumbar spondylosis T10-S1, grade I spondylolisthesis L4-L5, and central disc protrusion L3-L4 and L4-L5), and treatment to date (PT, acupuncture, lumbar epidural steroid injection, and medications). 4/17/13 and 6/12/13 medical report's discussion identify a request for decompression and spinal fusion L3-L4 and L4-L5, utilizing a lateral approach with interbody fusion cages at L3-L4 and L4-L5 followed by bilateral L3-L4 and L4-L5 laminotomy and instrumented spinal fusion. 8/7/13 utilization review identifies that in the case discussion with [REDACTED], he indicated that the May 2013 MRI report doesn't belong to the patient, and no corrected MRI had been received. There is no documentation of additional objective (sensory changes, motor changes, or reflex changes) radicular findings in the L4 nerve root distribution and imaging findings at each of the requested levels.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Lumbar Fusion:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation (ODG) Low Back- Lumbar & Thoracic Fusion (spinal)

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 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 to resolve disabling radicular symptoms) 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 additional 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 strain, thoracolumbar spondylosis T10-S1, grade I spondylolisthesis L4-L5, and central disc protrusion L3-L4 and L4-L5; subjective (pain, numbness, and tingling) radicular findings in each of the requested nerve root distributions; and failure of conservative treatment. However, despite documentation of objective (sensory changes) radicular findings in the L5 nerve root distribution, there is no documentation of objective findings in the L4 nerve root distribution. In addition, despite the imaging findings (MRI lumbosacral (5/11/13) identifying diffuse bulging of the annulus in combination with minimal facet hypertrophy at L3-4 which mildly flatten the anterior thecal sac without canal stenosis or focal nerve root impingement as well as disc bulge extending into the neural foramina slightly narrowing the neural foramina bilaterally; mild facet hypertrophy at L4-5 without canal or foraminal stenosis), and given that [REDACTED] indicates that the May 2013 MRI report doesn't belong to the patient, there is no documentation of imaging findings at each of the requested levels. Furthermore, there is no documentation of an indication for fusion (instability OR a statement that decompression will create surgically induced instability to resolve disabling radicular symptoms). Therefore, based on guidelines and a review of the evidence, the request for lumbar fusion is not medically necessary.

**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 base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Hospital- Length of Stay (LOS)

**Decision rationale:** MTUS does not specifically address the issue. ODG identifies hospital LOS for up to 4 days in the management of lumbar decompression/fusion. Within the medical information available for review, there is documentation of a diagnosis of lumbar strain, thoracolumbar spondylosis T10-S1, grade I spondylolisthesis L4-L5, and central disc protrusion L3-L4 and L4-L5. However, given that the associated request for surgery is not medically necessary, the request for hospital stay is not medically necessary. Therefore, based on guidelines and a review of the evidence, the request for hospital stay is not medically necessary.

**Anti-Embolism Stocking:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee and Leg, Compression Garment

**Decision rationale:** MTUS does not specifically address the issue. ODG identifies that compression stockings are indicated in the management of telangiectases after sclerotherapy, varicose veins in pregnancy, the prevention of edema and deep vein thrombosis (DVT) as criteria necessary to support the medical necessity of compression stockings. Within the medical information available for review, there is documentation of a diagnosis of lumbar strain, thoracolumbar spondylosis T10-S1, grade I spondylolisthesis L4-L5, and central disc protrusion L3-L4 and L4-L5. However, given that the associated request for surgery is not medically necessary, the request for anti-embolism stocking is not medically necessary. Therefore, based on guidelines and a review of the evidence, the request for anti-embolism stocking is not medically necessary.

**Cybertech Back Brace:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 301. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back, Back brace, post operative (fusion)

**Decision rationale:** MTUS does not specifically address this issue. ODG identifies that there may be special circumstances (multilevel cervical fusion, thoracolumbar unstable fusion, non-instrumented fusion, mid-lumbar fractures, etc.) in which some external immobilization might be desirable. Within the medical information available for review, there is documentation of a diagnosis of lumbar strain, thoracolumbar spondylosis T10-S1, grade I spondylolisthesis L4-L5,

and central disc protrusion L3-L4 and L4-L5. However, given that the associated request for surgery is not medically necessary, the request for Cyberteck back brace is not medically necessary. Therefore, based on guidelines and a review of the evidence, the request for Cyberteck back brace is not medically necessary.