

<b>Case Number:</b>	CM14-0173879		
<b>Date Assigned:</b>	10/31/2014	<b>Date of Injury:</b>	01/25/1996
<b>Decision Date:</b>	12/17/2014	<b>UR Denial Date:</b>	04/10/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/09/2014

### 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 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 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 63-year-old female with a 1/25/96 date of injury, and L4-5 laminectomy and discectomy and posterior lumbar interbody fusion on September 2007. At the time (2/14/14) of request for authorization for L3-4 transforaminal lumbar interbody fusion and posterior spinal instrumentation and fusion; Inpatient 3 day length of stay; Removal of hardware at L4-5; MRI of the lumbar spine with and without contrast; Consultation pre-op psychiatric clearance; Pre-op medical clearance; LSO brace, purchase; Cold therapy unit rental x 30 days; Pneumatic intermittent compression device, purchase; Front wheeled walker, purchase; and Assistant surgeon, there is documentation of subjective (worsening low back pain which radiates to bilateral greater trochanters, bilateral thighs, dorsal aspect, and plantar aspect of feet) and objective (tenderness over the bilateral greater trochanters, 1+ right knee reflex, and decreased motor power of hip flexion and knee extension) findings, imaging findings (MRI of the lumbar spine (6/4/13) report revealed a 6.3 mm circumferential disc bulge which moderately impresses on the thecal sac, marked bilateral neural foraminal narrowing and a high-intensity zone is present within the posterior annular fibers of the disc which may represent an annular fissure/tear that may be associated with pain, and bilateral facet arthrosis at L3-4; and X-ray of the lumbar spine (7/26/13) report revealed L3-4 grade II spondylolisthesis), current diagnoses (L3-4 grade II spondylolisthesis, bilateral lumbar radiculopathy, and L3-4 stenosis), and treatment to date (medications and physical therapy). There is no documentation of the results of the requested preoperative psychiatric clearance.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**L3-4 transforaminal lumbar interbody fusion and posterior spinal instrumentation and fusion: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Lumbar Spine Guidelines

**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

**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 (pain, numbness or tingling in a nerve root distribution) which confirm presence of radiculopathy, objective findings (sensory changes, motor changes, or reflex changes (if reflex present)) that correlate with symptoms, and imaging findings (nerve root compression or MODERATE or greater central canal, lateral recess, or neural foraminal stenosis) in concordance between radicular findings on radiologic evaluation and physical exam findings, as criteria necessary to support the medical necessity of decompression. Within the medical information available for review, there is documentation of diagnoses of 4 grade II spondylolisthesis, bilateral lumbar radiculopathy, and L3-4 stenosis. In addition, there is documentation of failure of conservative treatment (medications and physical therapy). Furthermore, given documentation of subjective (worsening low back pain which radiates to bilateral greater trochanters, bilateral thighs, dorsal aspect, and plantar aspect of feet and objective (1+ right knee reflex) findings, there is documentation of severe and disabling lower leg symptoms. Moreover, given documentation of imaging findings (Lumbar MRI identifying a 6.3 mm circumferential disc bulge which moderately impresses on the thecal sac and marked bilateral neural foraminal narrowing at L3-L4), there is documentation of imaging findings (nerve root compression and MODERATE or greater neural foraminal stenosis). Lastly, given documentation of a prior fusion at an adjacent level, there is documentation of an indication for fusion (that decompression, without incorporation into previous adjacent level fusion, will create surgically induced instability). However, there is no documentation of the results of the requested preoperative psychiatric clearance. Therefore, based on guidelines and a review of the evidence, the request L3-4 transforaminal lumbar interbody fusion and posterior spinal instrumentation and fusion is not medically necessary.

**Associated surgical service: Inpatient 3 day length of stay: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Lumbar Spine Guidelines

**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.

**Removal of hardware at L4-5:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Lumbar Spine Guidelines

**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

**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 (pain, numbness or tingling in a nerve root distribution) which confirm presence of radiculopathy, objective findings (sensory changes, motor changes, or reflex changes (if reflex present)) that correlate with symptoms, and imaging findings (nerve root compression or MODERATE or greater central canal, lateral recess, or neural foraminal stenosis) in concordance between radicular findings on radiologic evaluation and physical exam findings, as criteria necessary to support the medical necessity of decompression. Within the medical information available for review, there is documentation of diagnoses of 4 grade II spondylolisthesis, bilateral lumbar radiculopathy, and L3-4 stenosis. In addition, there is documentation of failure of conservative treatment (medications and physical therapy). Furthermore, given documentation of subjective (worsening low back pain which radiates to bilateral greater trochanters, bilateral thighs, dorsal aspect, and plantar aspect of feet and objective (1+ right knee reflex) findings, there is documentation of severe and disabling lower leg symptoms. Moreover, given documentation of imaging findings (Lumbar MRI identifying a 6.3 mm circumferential disc bulge which moderately impresses on the thecal sac and marked bilateral neural foraminal narrowing at L3-L4), there is documentation of imaging findings (nerve root compression and MODERATE or greater neural foraminal stenosis). Lastly, given documentation of a prior fusion at an adjacent level, there is documentation of an indication for fusion (that decompression, without incorporation into previous adjacent level fusion, will create surgically induced instability). However, there is no documentation of the results of the

requested preoperative psychiatric clearance. Therefore, based on guidelines and a review of the evidence, the request for Removal of hardware at L4-5 is not medically necessary.

**Associated surgical service: MRI of the lumbar spine with and without contrast:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Lumbar Spine Guidelines

**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 service: Consultation pre-op psychiatric clearance:** Overturned

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Lumbar Spine Guidelines

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 306.

**Decision rationale:** MTUS reference to ACOEM identifies that psychological screening should be considered before referral to surgery in-order to improve surgical outcomes. Within the medical information available for review, there is documentation of diagnoses of 4 grade II spondylolisthesis, bilateral lumbar radiculopathy, and L3-4 stenosis. In addition, there is documentation of a consideration for surgery. Therefore, based on guidelines and a review of the evidence, the request for Consultation pre-op psychiatric clearance is medically necessary.

**Associated surgical service: LSO brace, purchase:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Lumbar Spine Guidelines

**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 service: Pre-op medical clearance:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Lumbar Spine Guidelines

**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 service: Cold therapy unit rental x 30 days:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Lumbar Spine Guidelines

**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 service: Pneumatic intermittent compression device, purchase:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Lumbar Spine Guidelines

**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 service: Front wheeled walker, purchase:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Lumbar Spine Guidelines

**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 service: Assistant surgeon:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Lumbar Spine Guidelines

**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.