

<b>Case Number:</b>	CM14-0184377		
<b>Date Assigned:</b>	11/12/2014	<b>Date of Injury:</b>	09/17/2012
<b>Decision Date:</b>	12/15/2014	<b>UR Denial Date:</b>	10/24/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/05/2014

### 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 is a 48-year-old male with a 9/17/12 date of injury. At the time (10/15/14) of request for authorization for anterior lumbar discectomy followed by interbody fusion L4-L5 and L5-S1 combined with posterior decompression and fusion, Associated surgical service: 3 day inpatient stay, Associated surgical service: pre-operative clearance, SpinaLogic bone growth stimulator, Cybertech back brace, 4 point front wheel walker, and Vascutherm cold compression unit, there is documentation of subjective (low back pain radiating to bilateral lower extremities with numbness and tingling over left lower extremities) and objective (paraspinal as well as gluteal muscle spasms, decreased bilateral plantar as well as dorsiflexion strength, loss of sensation over bilateral L5/S1 nerve root distribution, and positive bilateral straight leg raise) findings, imaging findings (reported MRI lumbar spine (8/24/13) revealed L5-S1 central/right paracentral disc extrusion impinging on the right S1 nerve root and L4-5 moderate bilateral facet and ligamentum hypertrophy with moderate central stenosis; report not available for review), current diagnoses (4-5mm disc herniation at L4-5 and L5-S1, bilateral lower extremity radiculopathy, and 6mm retrolisthesis at L4-L5), and treatment to date (physical therapy and medications). Regarding anterior lumbar discectomy followed by interbody fusion L4-L5 and L5-S1 combined with posterior decompression and fusion, there is no documentation of subjective (pain, numbness or tingling) findings which confirms presence of radiculopathy; an imaging report; and an Indication for fusion (instability (imaging demonstrating 4.5 mm or greater movement)).

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Anterior lumbar discectomy followed by interbody fusion L4-L5 and L5-S1 combined with posterior decompression and fusion: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-330. 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 (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/laminotomy. Within the medical information available for review, there is documentation of diagnoses of 4-5mm disc herniation at L4-5 and L5-S1, bilateral lower extremity radiculopathy, and 6mm retrolisthesis at L4-L5. In addition, given documentation of objective (decreased bilateral plantar as well as dorsiflexion strength and loss of sensation over bilateral L5/S1 nerve root distribution) findings, there is documentation of objective (sensory changes and motor changes) findings which confirms presence of radiculopathy. Furthermore, there is documentation of failure of conservative treatment. However, despite nonspecific documentation of subjective (low back pain radiating to bilateral lower extremities with numbness and tingling over left lower extremities), there is no specific (to a nerve root distribution) documentation of subjective (pain, numbness or tingling) findings which confirms presence of radiculopathy. In addition, despite documentation of medical reports' reported imaging findings (MRI of lumbar spine identifying L5-S1 central/right paracentral disc extrusion impinging on the right S1 nerve root and L4-5 moderate bilateral facet and ligamentum hypertrophy with moderate central stenosis), there is no documentation of an imaging report. Furthermore, despite documentation of a diagnosis (4-5mm disc herniation at L4-5 and L5-S1 and 6mm retrolisthesis at L4-L5), there is documentation of an Indication for fusion (instability (imaging demonstrating 4.5 mm or greater movement)). Therefore, based on guidelines and a review of the evidence, the request for anterior lumbar discectomy followed by interbody fusion L4-L5 and L5-S1 combined with posterior decompression and fusion is not medically necessary.

**Associated surgical service: 3 day inpatient 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 service: pre-operative clearance:** 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.

**spinalogic bone growth stimulator:** 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.

**Cybertach 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.

**4 point 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.

**Vascutherm cold compression unit:** 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.