

<b>Case Number:</b>	CM14-0183358		
<b>Date Assigned:</b>	11/12/2014	<b>Date of Injury:</b>	01/31/1995
<b>Decision Date:</b>	03/09/2015	<b>UR Denial Date:</b>	10/06/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/04/2014

### 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. 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: California  
 Certification(s)/Specialty: Orthopedic 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:

According to the records made available for review, this is a 44-year-old female with a 1/31/95 date of injury. At the time (9/8/14) of request for authorization for Lumbar decompression including laminectomy, discectomy, facetectomy, foraminotomy at L4; Lumbar decompression including laminectomy, discectomy, facetectomy, foraminotomy at L5; Lumbar decompression including laminectomy, discectomy, facetectomy, foraminotomy at S1; Fusion with iliac crest bone graft and instruments including cages and pedicle screws; Pre-op medical clearance: EKG; Laboratory; Chest X-ray; Lumbar spine X-ray; MRI of the lumbar spine; Inpatient stay (3 days); Assistant surgeon; Cell Saver (Intraoperative Cell Salvage Machine); Intraoperative Monitoring Service: SSEP and EMG; Cold therapy unit (7 days); Bone growth stimulator, purchase; purchase of 3-1 commode; purchase of shower chair; purchase of back brace; post-operative physical therapy - lumbar spine, 8 visits; and 6 post-operative visits, there is documentation of subjective (chronic low back pain) and objective (decreased lumbar range of motion) findings, imaging findings (MRI lumbar spine (1/18/13) report revealed 3mm right foraminal disc protrusion with mild narrowing of right neural foramen of L4-5 and 5mm right lateral to right foraminal disc protrusion with moderate narrowing of right neural foramina at L5-S1), current diagnoses (herniated nucleus pulposus of lumbar spine), and treatment to date (acupuncture and medications). Regarding Lumbar decompression including laminectomy, discectomy, facetectomy, foraminotomy at L4, there is no documentation of subjective (pain, numbness or tingling) and objective (sensory changes, motor changes, or reflex changes) findings which confirm presence of radiculopathy; imaging findings (nerve root compression or moderate neural foraminal

stenosis); failure of additional conservative treatment (activity modification and physical modalities); and an Indication for fusion (instability or a statement that decompression will create surgically induced instability). Regarding Lumbar decompression including laminectomy, discectomy, facetectomy, foraminotomy at L5 and Lumbar decompression including laminectomy, discectomy, facetectomy, foraminotomy at S1, there is no documentation of subjective (pain, numbness or tingling) and objective (sensory changes, motor changes, or reflex changes) findings which confirm presence of radiculopathy; failure of additional conservative treatment (activity modification and physical modalities); and an Indication for fusion (instability or a statement that decompression will create surgically induced instability).

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

#### **Lumbar Decompression Including Laminectomy, Discectomy, Facetectomy, Foraminotomy at L4: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 306. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back

**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:** The ACOEM Practice Guidelines 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. The Official Disability Guidelines 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, and failure of conservative treatment (activity modification, medications, and physical modalities), as criteria necessary to support the medical necessity of decompression/laminotomy. Within the medical information available for review, there is documentation of a diagnosis of herniated nucleus pulposus of lumbar spine. In addition, there is documentation of failure of conservative treatment (medications). However, despite non-specific documentation of subjective (chronic low back pain) and objective (decreased lumbar range of motion) findings, there is no specific (to a nerve root distribution) documentation of subjective (pain, numbness or tingling) and objective (sensory changes, motor changes, or reflex changes) findings which confirm presence of radiculopathy. In addition, despite documentation of imaging finding (MRI of lumbar spine identifying 3mm right foraminal disc protrusion with mild

narrowing of right neural foramen of L4-5), there is no documentation of imaging findings (nerve root compression or moderate neural foraminal stenosis). Furthermore, there is no documentation of failure of additional conservative treatment (activity modification and physical modalities); and an Indication for fusion (instability or a statement that decompression will create surgically induced instability). Therefore, based on guidelines and a review of the evidence, the request for Lumbar decompression including laminectomy, discectomy, facetectomy, foraminotomy at L4 is not medically necessary.

### **Lumbar Decompression Including Laminectomy, Discectomy, Facetectomy, Foraminotomy at L5: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 306. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back

**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:** The ACOEM Practice Guidelines 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. The Official Disability Guidelines 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 a diagnosis of herniated nucleus pulposus of lumbar spine. In addition, there is documentation of failure of conservative treatment (medications). Furthermore, given documentation of imaging finding (MRI of lumbar spine identifying moderate narrowing of right neural foramina at L5-S1), there is documentation of imaging findings (moderate neural foraminal stenosis). However, despite non-specific documentation of subjective (chronic low back pain) and objective (decreased lumbar range of motion) findings, there is no specific (to a nerve root distribution) documentation of subjective (pain, numbness or tingling) and objective (sensory changes, motor changes, or reflex changes) findings which confirm presence of radiculopathy. In addition, there is no documentation of failure of additional conservative treatment (activity modification and physical modalities); and an Indication for fusion (instability or a statement that decompression will create surgically induced instability). Therefore, based on guidelines and a review of the evidence, the request for Lumbar decompression including laminectomy, discectomy, facetectomy, foraminotomy at L5 is not medically necessary.

**Lumbar Decompression Including Laminectomy, Discectomy, Facectomy, Foraminotomy at S1: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 306. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back

**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:** The ACOEM Practice Guidelines 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. The Official Disability Guidelines 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 a diagnosis of herniated nucleus pulposus of lumbar spine. In addition, there is documentation of failure of conservative treatment (medications). Furthermore, given documentation of imaging finding (MRI of lumbar spine identifying moderate narrowing of right neural foramina at L5-S1), there is documentation of imaging findings (moderate neural foraminal stenosis). However, despite non-specific documentation of subjective (chronic low back pain) and objective (decreased lumbar range of motion) findings, there is no specific (to a nerve root distribution) documentation of subjective (pain, numbness or tingling) and objective (sensory changes, motor changes, or reflex changes) findings which confirm presence of radiculopathy. In addition, there is no documentation of failure of additional conservative treatment (activity modification and physical modalities); and an Indication for fusion (instability or a statement that decompression will create surgically induced instability). Therefore, based on guidelines and a review of the evidence, the request for Lumbar decompression including laminectomy, discectomy, facectomy, foraminotomy at S1 is not medically necessary.

**Fusion with Lilac Crest Bone Graft and Instruments Including Cages and Pedicle Screws: 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.

**Pre-Operative Medical Clearance: EKG:** 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.

**Laboratory:** 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.

**Chest X-ray:** 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.

**Lumbar Spine X-ray:** 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.

**MRI of the Lumbar Spine:** 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.

**Inpatient Stay (3-days): 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.

**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.

**Cell Saver (Intraoperative Cell Salvage Machine): 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.

**Intraoperative Monitoring Service: SSEP and EMG: 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 Unit (7 days):** 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.

**Bone Growth Stimulator (purchase):** 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.