

<b>Case Number:</b>	CM15-0006272		
<b>Date Assigned:</b>	01/26/2015	<b>Date of Injury:</b>	08/25/2004
<b>Decision Date:</b>	03/27/2015	<b>UR Denial Date:</b>	12/24/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/12/2015

### 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: New York

Certification(s)/Specialty: Neurological 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:

This 56 year old male truck driver reported an industrial injury on 8/25/04 from repetitive motion with pain in the neck and upper extremities with subsequent ongoing low back pain. Magnetic resonance imaging lumbar spine (5/19/14) showed severe degenerative disc disease and modic changes at L3-4 and L4-5 with focal spinal stenosis. No disc extrusion or sequestration was noted. EMGs of the lower extremities on 05/27/14 were normal and nerve conduction studies suggested a peripheral polyneuropathy. The pain management consultant on 06/23/2014 noted the worker had a long history of narcotic dependency, major depression and opined he was a poor surgical candidate. He had been treated with numerous trigger point injections as well as epidural steroid injections to his neck and back. In a PR-2 dated 12/10/14, the injured worker complained of moderate to severe back pain with radiation predominantly into the left leg. The physician noted that the injured worker was having severe pain and was unable to ambulate for more than a few blocks. Current diagnosis was lumbar severe disc space collapse and local spinal stenosis at L3-4 and L4-5 status post multiple epidural steroid injections and lumbar degenerative disc disease at L3-4 and L4-5. Physical exam was remarkable for focal tenderness along the L3-4, L4-5 and L5-S1 posterior spinous processes and paraspinal muscles. The physician noted that the injured worker needed to be assisted from a supine to a sitting position and standing in an upright position. The injured worker forward flexed with his hands to about his mid femurs. Range of motion exam showed extension 10 degrees, bilateral lateral bending was equal and symmetric at 10 degrees. The physician recommended decompressive lumbar laminectomy L3-4, L4-5 w/disc excision at two levels, posterior lumbar interbody fusion: L3-4,

L4-5 w/bilateral pedicle screws at L3, L4, L5. On 12/24/14, Utilization Review noncertified a request for decompressive lumbar laminectomy L3-4, L4-5 w/disc excision at two levels, posterior lumbar interbody fusion: L3-4, L4-5 w/bilateral pedicle screws at L3, L4, L5, pre-operative laboratory: CBC, PT, PTT, LYTRES, BUN, UA, CHEM7, Chest X-ray, EKG, inpatient hospital stay for 3-4 days, associated Surgical Services: front wheeled chair walker, Cold therapy unit, lumbar brace, 3 in 1 commode, bone stimulator and shower chair and postoperative physical therapy x 2 citing CA MTUS and ODG guidelines.

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

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

**Associated Surgical Service: Front wheeled chair walker: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Medicare National Coverage Determination Manual

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Since the requested treatment: Posterior interbody fusion: L3-4, L4-5 w/bilateral pedicle screws at L3, L4, L5 is not medically necessary and appropriate then the requested treatment: Associated Surgical Service: Front wheeled chair walker is not medically necessary and appropriate.

**Decision rationale:** Since the requested treatment: Posterior interbody fusion: L3-4, L4-5 w/bilateral pedicle screws at L3, L4, L5 is not medically necessary and appropriate, then the requested treatment: Associated Surgical Service: Front wheeled chair walker is not medically necessary and appropriate.

**Pre-Operative laboratory: CBC, PT, PTT, LYTRES, BUN, UA, CHEM7, Chest X-ray, EKG: 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), Low Back Chapter

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Since the requested treatment: Posterior interbody fusion:L3-4, L4-5 w/bilateral pedicle screws at L3, L4, L5 is not medically necessary and appropriate then the requested treatment: Pre-operative laboratory: CBC,PT,PTT,LYTRES,BUN,UA,CHEM7, Chest X-ray, EKG is not medically necessary and appropriate.

**Decision rationale:** Since the requested treatment: Posterior interbody fusion: L3-4, L4-5 w/bilateral pedicle screws at L3, L4, L5 is not medically necessary and appropriate.then the requested treatment: Pre-operative laboratory: CBC,PT,PTT,LYTRES,BUN,UA,CHEM7, Chest X-ray, EKG is not medically necessary and appropriate.

**Associated Surgical Service: Cold therapy unit: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Medical literature found in Medline

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Since the requested treatment: Posterior interbody fusion: L3-4, L4-5 w/bilateral pedicle screws at L3, L4, L5 is not medically necessary and appropriate then the requested treatment: Associated Surgical Service: cold therapy unit is not medically necessary and appropriate

**Decision rationale:** Since the requested treatment: Posterior interbody fusion: L3-4, L4-5 w/bilateral pedicle screws at L3, L4, L5 is not medically necessary and appropriate then the requested treatment: Associated Surgical Service: cold therapy unit is not medically necessary and appropriate.

**Associated Surgical Service: Lumbar brace: Upheld**

**Claims Administrator 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 Chapter

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Since the requested treatment: Posterior interbody fusion: L3-4, L4-5 w/bilateral pedicle screws at L3, L4, L5 is not medically necessary and appropriate then the requested treatment: Associated Surgical service: lumbar brace is not medically necessary and appropriate.

**Decision rationale:** Since the requested treatment: Posterior interbody fusion: L3-4, L4-5 w/bilateral pedicle screws at L3, L4, L5 is not medically necessary and appropriate then the requested treatment: Associated Surgical service: lumbar brace is not medically necessary and appropriate.

**Decompressive lumbar laminectomy L3-4, L4-5 w/disc excision at two levels: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Page(s): 305-307. 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): 305,307.

**Decision rationale:** The California MTUS guidelines note that surgical consultation is indicated if the patient has clear clinical, imaging and electrophysiologic evidence of a lesion that has been shown both in the short and long term from surgical repair. Documentation shows this worker has had a long term narcotic dependency and has observed to be a poor surgical candidate. He has

not had clear clinical and imaging correlation in that his MRI scan has not shown disc extrusion or sequestration. Documentation has not shown disabling abnormalities accompanying objective signs of neural compromise. The guidelines note there is no scientific evidence about the long-term effectiveness of any form of surgical decompression or fusion for degenerative lumbar spondylosis. Therefore the requested treatment decompressive lumbar laminectomy L3-4, L4-5 w/disc excision at two levels is not medically necessary or appropriate.

**Posterior lumbar interbody fusion: L3-4, L4-5 w/bilateral pedical screws at L3, L4, L5:**  
Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Page(s): 305-307.  
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): 307.

**Decision rationale:** The California MTUS guidelines recommend lumbar fusion in cases of trauma-related spinal fracture, dislocation or instability. Documentation shows none of these conditions are present in this patient. Therefore, the requested treatment: Posterior interbody fusion: L3-4, L4-5 w/bilateral pedicle screws at L3, L4, L5 is not medically necessary and appropriate.

**Inpatient hospital stay for 3-4 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), Low Back Chapter

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Since the requested treatment: Posterior interbody fusion: L3-4, L4-5 w/bilateral pedicle screws at L3, L4, L5 is not medically necessary and appropriate then the inpatient hospital stay 3-4 days is not medically necessary and appropriate.

**Decision rationale:** Since the requested treatment: Posterior interbody fusion: L3-4, L4-5 w/bilateral pedicle screws at L3, L4, L5 is not medically necessary and appropriate, then the inpatient hospital stay 3-4 days is not medically necessary and appropriate.

**Associated Surgical Service: 3 in 1 Commode:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Medicare National Coverage Determination Manual

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Since the requested treatment: Posterior interbody

fusion:L3-4, L4-5 w/bilateral pedicle screws at L3, L4, L5 is not medically necessary and appropriate then the requested treatment: Associated Surgical Service: 3 in 1 commode is not medically necessary and appropriate

**Decision rationale:** Since the requested treatment: Posterior interbody fusion: L3-4, L4-5 w/bilateral pedicle screws at L3, L4, L5 is not medically necessary and appropriate then the requested treatment: Associated Surgical Service: 3 in 1 commode is not medically necessary and appropriate.

**Associated Surgical Service: Bone stimulator:** 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), Neck and Upper Back Chapter

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Since the requested treatment: Posterior interbody fusion: L3-4, L4-5 w/bilateral pedicle screws at L3, L4, L5 is not medically necessary and appropriate. then the requested treatment: Associated Surgical Service: bone stimulator is not medically necessary and appropriate

**Decision rationale:** Since the requested treatment: Posterior interbody fusion: L3-4, L4-5 w/bilateral pedicle screws at L3, L4, L5 is not medically necessary and appropriate then the requested treatment: Associated Surgical Service: bone stimulator is not medically necessary and appropriate.

**Associated Surgical Service: Shower chair:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Medicare DME MAC

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Since the requested treatment: Posterior interbody fusion: L3-4, L4-5 w/bilateral pedicle screws at L3, L4, L5 is not medically necessary and appropriate then the requested treatment: Associated Surgical Service: shower chair is not medically necessary and appropriate

**Decision rationale:** Since the requested treatment: Posterior interbody fusion: L3-4, L4-5 w/bilateral pedicle screws at L3, L4, L5 is not medically necessary and appropriate then the requested treatment: Associated Surgical Service: shower chair is not medically necessary and appropriate.

**Post-Operative physical therapy:** Upheld

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Since the requested treatment: Posterior interbody fusion: L3-4, L4-5 w/bilateral pedicle screws at L3, L4, L5 is not medically necessary and appropriate then the requested treatment: Associated Surgical Service: Post-operative physical therapy is not medically necessary and appropriate.

**Decision rationale:** Since the requested treatment: Posterior interbody fusion: L3-4, L4-5 w/bilateral pedicle screws at L3, L4, L5 is not medically necessary and appropriate then the requested treatment: Associated Surgical Service: Post-operative physical therapy is not medically necessary and appropriate.