

<b>Case Number:</b>	CM15-0013308		
<b>Date Assigned:</b>	03/09/2015	<b>Date of Injury:</b>	04/01/2010
<b>Decision Date:</b>	04/17/2015	<b>UR Denial Date:</b>	12/22/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/22/2015

### 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:

The injured worker is a 54-year-old male who sustained an industrial injury on 04/01/2010. Diagnoses include L4-5, and L5-S1 disc degeneration, mild foraminal narrowing at L5-S1, L4-L5 facet arthropathy and left lateral stenosis, L4-L5 and L5-S1 disc herniation with annular tear at L4-L5, bilateral leg radiculopathy, and status post bilateral L4-L5 and L5-S1 laminectomies, mesiofacetectomies, and foraminotomies and repair of a cerebral spinal fluid leak/dural tear with laminotomy on 4/30/2012. Treatment to date has included failed physical therapy, chiropractic therapy, acupuncture, and has had bilateral decompression and laminectomies on 4/30/2012 which improved his leg but not his back pain. A physician progress note dated 12/09/2014 documents the injured worker was previously denied authorization for an L4-5 and L5-S1 anterior and posterior fusion. He continues to complain of low back pain with numbness radiating down the right greater than the left anterior thighs through the shins to the top of the feet. Range of motion is decreased and he has decreased sensation in the L3, L4, and L5 Dermatome distributions. There is positive Faber's and Fortin's on the left. Treatment requested is for Associated Surgical Service: 3 in 1 Commode, Associated Surgical Service: Cold Therapy Unit (30 Day Rental), Associated Surgical Service: Front Wheel Walker, Associated Surgical Service: Intraoperative Spinal Cord Monitoring, Associated Surgical Service: Lumbar LSO, Associated Surgical Service: Orthofix Bone Growth Stimulator, Associated Surgical Service: Pneumatic Intermittent Compression Device, Associated Surgical Service: Vascular/Co-Surgeon, Associated surgical service: 3 days inpatient stay, Associated surgical service: Assistant

Surgeon, Associated surgical service: Medical Pre-op Clearance, and L4-S1 Anterior and Posterior Fusion with Cage and Instrumentation.

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

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

#### **L4-S1 Anterior and Posterior Fusion with Cage and Instrumentation: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 307 and 310. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back Chapter.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 304-307.

**Decision rationale:** The California MTUS guidelines do recommend spinal fusion for traumatic vertebral fracture, dislocation and instability. This patient has not had a vertebral fracture, dislocation or any evidence of instability. The provider argues that discography provides evidence for the necessity of fusion but the MTUS guidelines do not recommend discography be used as pre-operative support for fusion. The provider argues that a wider lumbar decompression is needed for this patient which would then cause instability. MITUS guidelines indicate that clear clinical, imaging and electrophysiological evidence of a lesion which is known to respond to surgical repair both in the short and long term be presented. Documentation does not show this. The requested treatment L4-S1 anterior and posterior fusions with cage and instrumentation are not medically indicated and appropriate.

#### **Associated surgical service: 3 days inpatient 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, Low Back Chapter, hospital length of stay (LOS) guidelines.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Since the requested treatment L4-S1 anterior and posterior fusions with cage and instrumentation is not medically indicated and appropriate, then the Requested Treatment: Associated surgical service: 3 days inpatient stay is not medically indicated and appropriate.

**Decision rationale:** Since the requested treatment L4-S1 anterior and posterior fusions with cage and instrumentation is not medically indicated and appropriate, then the Requested Treatment: Associated surgical service: 3 days inpatient stay is not medically indicated and appropriate.

#### **Associated surgical service: Medical Pre-op Clearance: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Institute for Clinical Systems Improvement (ICSI), Preoperative evaluation. Bloomington (MN); 2010 Jun 40 p.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Since the requested treatment L4-S1 anterior and posterior fusions with cage and instrumentation is not medically indicated and appropriate, then the Requested Treatment: Associated surgical service: Medical Pre-op Clearance is not medically indicated and appropriate.

**Decision rationale:** Since the requested treatment L4-S1 anterior and posterior fusions with cage and instrumentation is not medically indicated and appropriate, then the Requested Treatment: Associated surgical service: Medical Pre-op Clearance is not medically indicated and appropriate.

**Associated surgical service: 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 base their decision on the MTUS. Decision based on Non-MTUS Citation Since the requested treatment L4-S1 anterior and posterior fusions with cage and instrumentation is not medically indicated and appropriate, then the Requested Treatment: Associated surgical service: assistant surgeon is not medically indicated and appropriate.

**Decision rationale:** Since the requested treatment L4-S1 anterior and posterior fusions with cage and instrumentation is not medically indicated and appropriate, then the Requested Treatment: Associated surgical service: assistant surgeon is not medically indicated and appropriate.

**Associated Surgical Service: Vascular/Co-Surgeon: 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 Since the requested treatment L4-S1 anterior and posterior fusions with cage and instrumentation is not medically indicated and appropriate, then the Requested Treatment: Associated surgical service: Vascular/Co-surgeon is not medically indicated and appropriate.

**Decision rationale:** Since the requested treatment L4-S1 anterior and posterior fusions with cage and instrumentation is not medically indicated and appropriate, then the Requested Treatment: Associated surgical service: Vascular/Co-surgeon is not medically indicated and appropriate.

**Associated Surgical Service: Intraoperative Spinal Cord Monitoring: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, 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 L4-S1 anterior and posterior fusions with cage and instrumentation is not medically indicated and appropriate, then the Requested Treatment: Associated surgical service: Intraoperative Spinal Cord Monitoring is not medically indicated and appropriate.

**Decision rationale:** Since the requested treatment L4-S1 anterior and posterior fusions with cage and instrumentation is not medically indicated and appropriate, then the Requested Treatment: Associated surgical service: Intraoperative Spinal Cord Monitoring is not medically indicated and appropriate.

**Associated Surgical Service: Orthofix Bone Growth 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, Lumbar Chapter.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Since the requested treatment L4-S1 anterior and posterior fusions with cage and instrumentation is not medically indicated and appropriate, then the Requested Treatment: Associated surgical service: Orthofix Bone Growth stimulator is not medically indicated and appropriate.

**Decision rationale:** Since the requested treatment L4-S1 anterior and posterior fusions with cage and instrumentation is not medically indicated and appropriate, then the Requested Treatment: Associated surgical service: Orthofix Bone Growth stimulator is not medically indicated and appropriate.

**Associated Surgical Service: Lumbar LSO: 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, 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 L4-S1 anterior and posterior fusions with cage and instrumentation is not medically indicated and appropriate, then the Requested Treatment: Associated surgical service: Lumbar LSO is not medically indicated and appropriate.

**Decision rationale:** Since the requested treatment L4-S1 anterior and posterior fusions with cage and instrumentation is not medically indicated and appropriate, then the Requested Treatment: Associated surgical service: Lumbar LSO is not medically indicated and appropriate.

**Associated Surgical Service: Cold Therapy Unit (30 Day Rental): Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, 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 L4-S1 anterior and posterior fusions with cage and instrumentation is not medically indicated and appropriate, then the Requested Treatment: Associated surgical service: cold therapy unit (30 day rental) is not medically indicated and appropriate.

**Decision rationale:** Since the requested treatment L4-S1 anterior and posterior fusions with cage and instrumentation is not medically indicated and appropriate, then the Requested Treatment: Associated surgical service: cold therapy unit (30-day rental) is not medically indicated and appropriate.

**Associated Surgical Service: Pneumatic Intermittent Compression Device: 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 Since the requested treatment L4-S1 anterior and posterior fusions with cage and instrumentation is not medically indicated and appropriate, then the Requested Treatment: Associated surgical service: Pneumatic Intermittent compression device is not medically indicated and appropriate.

**Decision rationale:** Since the requested treatment L4-S1 anterior and posterior fusions with cage and instrumentation is not medically indicated and appropriate, then the Requested Treatment: Associated surgical service: Pneumatic Intermittent compression device is not medically indicated 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 Anthem: Durable Medical Equipment.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Since the requested treatment L4-S1 anterior and posterior fusions with cage and instrumentation is not medically indicated and appropriate, then

the Requested Treatment: Associated surgical service: 3 in 2 Commode is not medically indicated and appropriate.

**Decision rationale:** Since the requested treatment L4-S1 anterior and posterior fusions with cage and instrumentation is not medically indicated and appropriate, then the Requested Treatment: Associated surgical service: 3 in 2 Commode is not medically indicated and appropriate.

**Associated Surgical Service: Front Wheel Walker:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Medicare Claims Processing Manual, Chapter 20, Durable Medical Equipments, Prosthetics and Orthotics, and Supplies: [http://www.cms.hhs.gov/manuals/103\\_cov\\_determ/ncd103c1\\_Part4.pdf](http://www.cms.hhs.gov/manuals/103_cov_determ/ncd103c1_Part4.pdf).

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Since the requested treatment L4-S1 anterior and posterior fusions with cage and instrumentation is not medically indicated and appropriate, then the Requested Treatment: Associated surgical service: Front wheel walker is not medically indicated and appropriate.

**Decision rationale:** Since the requested treatment L4-S1 anterior and posterior fusions with cage and instrumentation is not medically indicated and appropriate, then the Requested Treatment: Associated surgical service: Front wheel walker is not medically indicated and appropriate.