

<b>Case Number:</b>	CM14-0093161		
<b>Date Assigned:</b>	08/08/2014	<b>Date of Injury:</b>	02/15/2012
<b>Decision Date:</b>	10/01/2014	<b>UR Denial Date:</b>	05/29/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/19/2014

### 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 Spine and is licensed to practice in Texas. 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:

The injured worker is a 61-year-old male, who reported injury on 02/15/2012. The injured worker's diagnoses included thoracic or lumbosacral neuritis or radiculitis unspecified. The mechanism of injury was the injured worker was assisting an obese patient to stand when the patient started to fall and the injured worker tried to keep the patient from falling; he injured his low back. The prior treatments were noted to include physical therapy, injections and medications. The prior surgeries were noted to include 2 laminectomies and an L3-5 laminotomy and foraminotomy on 09/11/2013. The medications included Norco 10/325, Anaprox 550 mg, and Prilosec 20 mg. The injured worker's EMG on 04/25/2013 revealed electrodiagnostic evidence of chronic left L4, L5, and S1 polyradiculopathy as well as sensory peripheral neuropathy, demyelinating in nature, affecting the lower extremities. This was noted to be prior to the surgical intervention of 09/11/2013. The injured worker underwent x-rays of the lumbar spine on 03/06/2014 with lateral flexion and extension views of the lumbar spine, which revealed decreased disc space narrowing at L4-5 and more severe at L5-S1. The injured worker underwent an MRI of the lumbar spine most recently on 04/03/2014, which revealed there was a laminectomy change at L4 and L5 levels. There was possible scar tissue encasing the traversing left L5 nerve at the L4-5 level. There was mild bilateral neural foraminal stenosis at L4-5. There were degenerative changes with right lateral recess narrowing at L3-4, contacting the traversing right L4 nerve. There was a left subarticular foraminal disc protrusion at L3-4, contacting the traversing left L4 nerve, and there was mild to moderate bilateral neural foraminal stenosis at this level. The documentation of 05/19/2014 revealed the injured worker had leg pain that had improved with surgery in September of 2013; however, the back pain had not improved. The injured worker's medications were noted to include Anaprox DS 550 mg tablets, Cymbalta 30 mg tablets, Norco 10/325 mg tablets, Lisinopril 20 mg tablets, Prilosec 20 mg tablets, and

Aleve 220 mg tablets. The present complaints were noted to include low back pain with numbness in the left buttock. The injured worker had complaints of right knee pain and right wrist pain. The physical examination revealed the injured worker had decreased sensation over the left L4, L5, and S1 dermatomes. The injured worker's ankle reflexes were absent bilaterally. The knee reflex was decreased to 1+ on the left knee. The motor power was 4/5 on the left for hip flexion, knee extension, and ankle dorsiflexion. The injured worker had a straight leg raise that was negative on the left with back pain only. The injured worker's straight leg raise was negative on the right at 90 degrees. The physician was noted to review the MRI of 04/03/2014, which the physician opined that the injured worker had an L4-5 and L5-S1 disc with lumbarized first sacral segment. The diagnoses included status post left L3-5 laminotomy and foraminotomy 09/11/2013, left L3-4 mild to moderate stenosis, moderately severe left L4 stenosis, left L3 and L4 radiculopathy with hip flexor and tibialis anterior weakness and status post prior laminectomies x2. The treatment plan included, the physician opined, the only real option to resolve the ongoing symptoms was further surgery, including a revision of the L3-4 and L4-5 laminectomy and a complete facetectomy on the left due to leg pain and a complete discectomy at L3-4 and L4-5 with caging instrumentation. As such, the request was made for an anterior lumbar interbody fusion and posterior spinal interbody fusion at L3-4 and L4-5 with a left facetectomy at L3-4 and L4-5 and a foraminotomy on the left at L3-4 and L4-5. Additionally, the request was made for an LSO brace, bone growth stimulator due to multilevel fusion, pneumatic intermittent compression device, postoperative physiotherapy 3 times a week x6 weeks, and preoperative medical clearance and chest x-ray. There was no Request for Authorization submitted to support the requests.

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

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

**Arthrodesis anterior interbody technique including minimal discectomy, QTY: 1: 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), Treatment in Workers Compensation (TWC): Web Based Version, Spinal Fusion

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-307.

**Decision rationale:** The American College of Occupational and Environmental Medicine indicate a surgical consultation may be appropriate for injured workers who have severe and disabling lower leg symptoms in a distribution consistent with abnormalities on imaging studies preferably with accompanying objective signs of neural compromise. There should be documentation of activity limitations due to radiating leg pain for more than 1 month or the extreme progression of lower leg symptoms, and clear clinical, imaging and electrophysiologic evidence of a lesion that has been shown to benefit in both the short and long term from surgical repair and documentation of a failure of conservative treatment to resolve disabling radicular symptoms. The clinical documentation submitted for review indicated the injured worker had been treated with physical therapy medicine. There were objective clinical findings upon physical examination, and there were imaging findings upon MRI imaging. However, there was a lack of documentation of electrophysiologic evidence of a lesion that has been shown to benefit in both the short and long term from surgical repair. There was a lack of documentation

indicating the duration of conservative care. The request as submitted failed to indicate the level and laterality for the requested surgical intervention. Given the above, the request for arthrodesis anterior interbody technique including minimal discectomy quantity 1 is not medically necessary.

**Arthrodesis anterior interbody technique including each additional interspace, QTY: 1:**  
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), Treatment in Workers Compensation (TWC): Web Based Version, Spinal Fusion

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-307.

**Decision rationale:** The American College of Occupational and Environmental Medicine indicate a surgical consultation may be appropriate for injured workers who have severe and disabling lower leg symptoms in a distribution consistent with abnormalities on imaging studies preferably with accompanying objective signs of neural compromise. There should be documentation of activity limitations due to radiating leg pain for more than 1 month or the extreme progression of lower leg symptoms, and clear clinical, imaging and electrophysiologic evidence of a lesion that has been shown to benefit in both the short and long term from surgical repair and documentation of a failure of conservative treatment to resolve disabling radicular symptoms. The clinical documentation submitted for review indicated the injured worker had been treated with physical therapy medicine. There were objective clinical findings upon physical examination, and there were imaging findings upon MRI imaging. However, there was a lack of documentation of electrophysiologic evidence of a lesion that has been shown to benefit in both the short and long term from surgical repair. There was a lack of documentation indicating the duration of conservative care. The request as submitted failed to indicate the level and laterality for the requested surgical intervention. Given the above, the request for Arthrodesis anterior interbody technique including each additional interspace, QTY: 1 is not medically necessary.

**Arthrodesis posterior or posterolateral technique single level lumbar, QTY: 1:** 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), Treatment in Workers Compensation (TWC): Web Based Version, Spinal Fusion

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-307.

**Decision rationale:** The American College of Occupational and Environmental Medicine indicate a surgical consultation may be appropriate for injured workers who have severe and disabling lower leg symptoms in a distribution consistent with abnormalities on imaging studies preferably with accompanying objective signs of neural compromise. There should be

documentation of activity limitations due to radiating leg pain for more than 1 month or the extreme progression of lower leg symptoms, and clear clinical, imaging and electrophysiologic evidence of a lesion that has been shown to benefit in both the short and long term from surgical repair and documentation of a failure of conservative treatment to resolve disabling radicular symptoms. The clinical documentation submitted for review indicated the injured worker had been treated with physical therapy medicine. There were objective clinical findings upon physical examination, and there were imaging findings upon MRI imaging. However, there was a lack of documentation of electrophysiologic evidence of a lesion that has been shown to benefit in both the short and long term from surgical repair. There was a lack of documentation indicating the duration of conservative care. The request as submitted failed to indicate the level and laterality for the requested surgical intervention. Given the above, the request for Arthrodesis posterior or posterolateral technique single level lumbar, QTY: 1 is not medically necessary.

**Internal spinal fixation by wiring of spinous processes, QTY: 1: 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), Treatment in Workers Compensation (TWC): Web Based Version, Spinal Fusion

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-307.

**Decision rationale:** The American College of Occupational and Environmental Medicine indicate a surgical consultation may be appropriate for injured workers who have severe and disabling lower leg symptoms in a distribution consistent with abnormalities on imaging studies preferably with accompanying objective signs of neural compromise. There should be documentation of activity limitations due to radiating leg pain for more than 1 month or the extreme progression of lower leg symptoms, and clear clinical, imaging and electrophysiologic evidence of a lesion that has been shown to benefit in both the short and long term from surgical repair and documentation of a failure of conservative treatment to resolve disabling radicular symptoms. The clinical documentation submitted for review indicated the injured worker had been treated with physical therapy medicine. There were objective clinical findings upon physical examination, and there were imaging findings upon MRI imaging. However, there was a lack of documentation of electrophysiologic evidence of a lesion that has been shown to benefit in both the short and long term from surgical repair. There was a lack of documentation indicating the duration of conservative care. The request as submitted failed to indicate the level and laterality for the requested surgical intervention. Given the above, the request for internal spinal fixation by wiring of spinous processes, QTY: 1 is not medically necessary.

**Anterior instrumentation; 2 to 3 vertebral segments, QTY: 1: 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), Treatment in Workers Compensation (TWC): Web Based Version, Spinal Fusion

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints  
Page(s): 305-307.

**Decision rationale:** The American College of Occupational and Environmental Medicine indicate a surgical consultation may be appropriate for injured worker's who have severe and disabling lower leg symptoms in a distribution consistent with abnormalities on imaging studies preferably with accompanying objective signs of neural compromise. There should be documentation of activity limitations due to radiating leg pain for more than 1 month or the extreme progression of lower leg symptoms, and clear clinical, imaging and electrophysiologic evidence of a lesion that has been shown to benefit in both the short and long term from surgical repair and documentation of a failure of conservative treatment to resolve disabling radicular symptoms. The clinical documentation submitted for review indicated the injured worker had been treated with physical therapy medicine. There were objective clinical findings upon physical examination, and there were imaging findings upon MRI imaging. However, there was a lack of documentation of electrophysiologic evidence of a lesion that has been shown to benefit in both the short and long term from surgical repair. There was a lack of documentation indicating the duration of conservative care. The request as submitted failed to indicate the level and laterality for the requested surgical intervention. Given the above, the request for Anterior instrumentation; 2 to 3 vertebral segments, QTY: 1 is not medically necessary.

**Cage dowels, QTY:3:** 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), Treatment in Workers Compensation (TWC): Web Based Version, Spinal Fusion

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints  
Page(s): 305-307.

**Decision rationale:** The American College of Occupational and Environmental Medicine indicate a surgical consultation may be appropriate for injured workers who have severe and disabling lower leg symptoms in a distribution consistent with abnormalities on imaging studies preferably with accompanying objective signs of neural compromise. There should be documentation of activity limitations due to radiating leg pain for more than 1 month or the extreme progression of lower leg symptoms, and clear clinical, imaging and electrophysiologic evidence of a lesion that has been shown to benefit in both the short and long term from surgical repair and documentation of a failure of conservative treatment to resolve disabling radicular symptoms. The clinical documentation submitted for review indicated the injured worker had been treated with physical therapy medicine. There were objective clinical findings upon physical examination, and there were imaging findings upon MRI imaging. However, there was a lack of documentation of electrophysiologic evidence of a lesion that has been shown to benefit in both the short and long term from surgical repair. There was a lack of documentation indicating the duration of conservative care. The request as submitted failed to indicate the level and laterality for the requested surgical intervention. Given the above, the request for Cage dowels, QTY: 3 is not medically necessary.

**Laminectomy (hemilaminectomy) with decompression of nerve root(s), QTY: 1: 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), Treatment in Workers Compensation (TWC): Web Based Version, Lumbosacral Nerve Root Decompression

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-307.

**Decision rationale:** The American College of Occupational and Environmental Medicine indicate a surgical consultation may be appropriate for injured workers who have severe and disabling lower leg symptoms in a distribution consistent with abnormalities on imaging studies preferably with accompanying objective signs of neural compromise. There should be documentation of activity limitations due to radiating leg pain for more than 1 month or the extreme progression of lower leg symptoms, and clear clinical, imaging and electrophysiologic evidence of a lesion that has been shown to benefit in both the short and long term from surgical repair and documentation of a failure of conservative treatment to resolve disabling radicular symptoms. The clinical documentation submitted for review indicated the injured worker had been treated with physical therapy medicine. There were objective clinical findings upon physical examination, and there were imaging findings upon MRI imaging. However, there was a lack of documentation of electrophysiologic evidence of a lesion that has been shown to benefit in both the short and long term from surgical repair. There was a lack of documentation indicating the duration of conservative care. The request as submitted failed to indicate the level and laterality for the requested surgical intervention. Given the above, the request for Laminectomy (hemilaminectomy) with decompression of nerve root(s), QTY: 1 is not medically necessary.

**Laminectomy (hemilaminectomy) with decompression of nerve root(s), QTY: 1: 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), Treatment in Workers Compensation (TWC): Web Based Version, Lumbosacral Nerve Root Decompression

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-307.

**Decision rationale:** The American College of Occupational and Environmental Medicine indicate a surgical consultation may be appropriate for injured workers who have severe and disabling lower leg symptoms in a distribution consistent with abnormalities on imaging studies preferably with accompanying objective signs of neural compromise. There should be documentation of activity limitations due to radiating leg pain for more than 1 month or the extreme progression of lower leg symptoms, and clear clinical, imaging and electrophysiologic evidence of a lesion that has been shown to benefit in both the short and long term from surgical repair and documentation of a failure of conservative treatment to resolve disabling radicular

symptoms. The clinical documentation submitted for review indicated the injured worker had been treated with physical therapy medicine. There were objective clinical findings upon physical examination, and there were imaging findings upon MRI imaging. However, there was a lack of documentation of electrophysiologic evidence of a lesion that has been shown to benefit in both the short and long term from surgical repair. There was a lack of documentation indicating the duration of conservative care. The request as submitted failed to indicate the level and laterality for the requested surgical intervention. Given the above, the request for Laminectomy (hemilaminectomy) with decompression of nerve root(s), QTY: 1 is not medically necessary.

**Front wheeled walker, QTY: 1: 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.

**Three (3) in one (1) commode, QTY: 1: 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 rental for 30 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.

**Pneumatic compression device, QTY: 1: 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, QTY: 1:** 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.

**LSO (Lumbosacral Orthotic Back) support brace, QTY: 1:** 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.

**Preoperative medical 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.