

<b>Case Number:</b>	CM15-0062526		
<b>Date Assigned:</b>	04/08/2015	<b>Date of Injury:</b>	04/30/2003
<b>Decision Date:</b>	05/08/2015	<b>UR Denial Date:</b>	03/12/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/02/2015

### 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 63-year-old male, who sustained an industrial injury on 4/30/03. He reported initial complaints of neck and low back and left shoulder resulting from a motor vehicle accident. The injured worker was diagnosed as having displacement of lumbar intervertebral disc without myelopathy; lumbago; thoracic or lumbosacral neuritis or radiculitis unspecified. Treatment to date has included status post laminectomy/discectomy L4-5 (1999); physical therapy; chiropractic therapy; lumbar epidural steroid injections (no benefit - no date); MRI lumbar Spine (8/20/14). Currently, per the PR-2 notes dated 2/19/15, the injured worker complains of chronic sharp, stabbing, and aching low back pain that radiated to both legs, right more than left with numbness in his feet. MRI of 8/20/14 demonstrates L3-S1 disc herniation with bilateral foraminal stenosis and significant facet arthropathy at L4-5 and foraminal stenosis. The provider recommends and is requesting (lumbar) L4-L5 Posterior Spinal Fusion and Decompression associated with a Posterior Laminoforaminotomy and Micro-decompression at the Bilateral L3-4 and L5-S1 (lumbosacral) which was denied at Utilization Review and since the surgery was denied the requests for an In Patient Length Of Stay - 3 Days; DME: Rental - Cooling Unit 4 weeks; walker; lumbar brace; Home Health- 2 times per week for 2 weeks we also denied.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**(lumbar) L4-L5 Posterior Spinal Fusion and Decompression associated with a Posterior Laminoforaminotomy and Microdecompression at the Bilateral L3-4 and L5-S1 (lumbosacral): Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-307. Decision based on Non-MTUS Citation Official Disability Guidelines: Low Back chapter - Fusion (spinal).

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

**Decision rationale:** The California MTUS guidelines do recommend a spinal fusion for traumatic vertebral fracture, dislocation and instability. This patient has not had any of these events. The California MTUS guidelines note that surgical consultation is indicated if the patient has persistent, severe and disabling lower extremity symptoms. The documentation shows this patient has been complaining of pain in the back radiating into the legs. Documentation does not disclose disabling lower extremity symptoms. The guidelines also list the criteria for clear clinical, imaging and electrophysiological evidence consistently indicating a lesion which has been shown to benefit both in the short and long term from surgical repair. Documentation does not show this evidence. The requested treatment is for a lumbar posterior spinal fusion. The guidelines note that the efficacy of fusion without instability has not been demonstrated. Documentation does not show instability. The requested treatment: (lumbar) L4-L5 Posterior Spinal Fusion and Decompression associated with a Posterior Laminoforaminotomy and Microdecompression at the Bilateral L3-4 and L5-S1 (lumbosacral) is NOT medically necessary and appropriate.

**In Patient Length Of Stay - 3 Days: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-307. Decision based on Non-MTUS Citation Official Disability Guidelines: Low Back chapter - Fusion (spinal).

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Since the requested treatment: (lumbar) L4-L5 Posterior Spinal Fusion and Decompression associated with a Posterior Laminoforaminotomy and Microdecompression at the Bilateral L3-4 and L5-S1 (lumbosacral) is NOT Medically necessary and appropriate, then the requested treatment: In Patient Length Of Stay - 3 Days Is / are NOT Medically necessary and appropriate.

**Decision rationale:** Since the requested treatment: (lumbar) L4-L5 Posterior Spinal Fusion and Decompression associated with a Posterior Laminoforaminotomy and Microdecompression at the Bilateral L3-4 and L5-S1 (lumbosacral) is NOT Medically necessary and appropriate, then the requested treatment: In Patient Length Of Stay - 3 Days is NOT Medically necessary and appropriate.

**Home Health- 2 times per week for 2 weeks: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-307. Decision based on Non-MTUS Citation Official Disability Guidelines: Low Back chapter - Fusion (spinal).

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Since the requested treatment: (lumbar) L4-L5 Posterior Spinal Fusion and Decompression associated with a Posterior Laminoforaminotomy and Microdecompression at the Bilateral L3-4 and L5-S1 (lumbosacral) is NOT Medically necessary and appropriate, then the requested treatment: Home Health- 2 times per week for 2 weeks is NOT Medically necessary and appropriate.

**Decision rationale:** Since the requested treatment: (lumbar) L4-L5 Posterior Spinal Fusion and Decompression associated with a Posterior Laminoforaminotomy and Microdecompression at the Bilateral L3-4 and L5-S1 (lumbosacral) is NOT Medically necessary and appropriate, then the requested treatment: Home Health- 2 times per week for 2 weeks is NOT Medically necessary and appropriate.

**DME (durable medical equipment) Rental - Cooling Unit, 4 Weeks: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-307. Decision based on Non-MTUS Citation Official Disability Guidelines: Low Back chapter - Fusion (spinal).

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Since the requested treatment: (lumbar) L4-L5 Posterior Spinal Fusion and Decompression associated with a Posterior Laminoforaminotomy and Microdecompression at the Bilateral L3-4 and L5-S1 (lumbosacral) is NOT Medically necessary and appropriate, then the requested treatment: DME (durable medical equipment) Rental - Cooling Unit, 4 Weeks is NOT Medically necessary and appropriate.

**Decision rationale:** Since the requested treatment: (lumbar) L4-L5 Posterior Spinal Fusion and Decompression associated with a Posterior Laminoforaminotomy and Microdecompression at the Bilateral L3-4 and L5-S1 (lumbosacral) is NOT Medically necessary and appropriate, then the requested treatment: DME (durable medical equipment) Rental - Cooling Unit, 4 Weeks is NOT Medically necessary and appropriate.

**DME (durable medical equipment) Purchase - Walker: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-307. Decision based on Non-MTUS Citation Official Disability Guidelines: Low Back chapter - Fusion (spinal).

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Since the requested treatment: (lumbar) L4-L5 Posterior

Spinal Fusion and Decompression associated with a Posterior Laminoforaminotomy and Microdecompression at the Bilateral L3-4 and L5-S1 (lumbosacral) is NOT Medically necessary and appropriate, then the requested treatment: DME (durable medical equipment) Purchase - Walker is NOT Medically necessary and appropriate.

**Decision rationale:** Since the requested treatment: (lumbar) L4-L5 Posterior Spinal Fusion and Decompression associated with a Posterior Laminoforaminotomy and Microdecompression at the Bilateral L3-4 and L5-S1 (lumbosacral) is NOT Medically necessary and appropriate, then the requested treatment: DME (durable medical equipment) Purchase - Walker is NOT Medically necessary and appropriate.

**DME (durable medical equipment) Purchase - Lumbar Brace:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-307. Decision based on Non-MTUS Citation Official Disability Guidelines: Low Back chapter - Fusion (spinal).

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Since the requested treatment: (lumbar) L4-L5 Posterior Spinal Fusion and Decompression associated with a Posterior Laminoforaminotomy and Microdecompression at the Bilateral L3-4 and L5-S1 (lumbosacral) is NOT Medically necessary and appropriate, then the requested treatment: DME (durable medical equipment) Purchase - lumbar brace is NOT Medically necessary and appropriate.

**Decision rationale:** Since the requested treatment: (lumbar) L4-L5 Posterior Spinal Fusion and Decompression associated with a Posterior Laminoforaminotomy and Microdecompression at the Bilateral L3-4 and L5-S1 (lumbosacral) is NOT Medically necessary and appropriate, then the requested treatment: DME (durable medical equipment) Purchase -lumbar brace is NOT Medically necessary and appropriate.