

<b>Case Number:</b>	CM13-0021453		
<b>Date Assigned:</b>	12/11/2013	<b>Date of Injury:</b>	07/12/2008
<b>Decision Date:</b>	03/19/2014	<b>UR Denial Date:</b>	08/28/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/09/2013

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Orthopedic Surgery, and is licensed to practice in California. 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 physician 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 records indicated that [REDACTED] requested on 09/20/13 an anterior discectomy and fusion at L4-5 and L5-S1 with allograft, cage, and plated that has been noted. It was documented that prior surgery included an L4-5 decompression and fusion and that he now had L5-S1 spondylolisthesis, which was problematic. There is a report of an MRI of the lumbar spine with adjunctive 3D myelography performed on 08/15/13 that revealed anterior wedging at the L4 vertebral body, patent spinal canal, degenerative changes, mild to moderate neuroforaminal narrowing most conspicuous from L3-S1, but no evidence of significant disc herniation or neurocompressive lesion. There was no documentation of a tumor, instability, or infection. On 11/12/13 [REDACTED] performed an anterior lumbar spinal fusion. The specific report was not available for review, but the general surgeon's report of his retroperitoneal L4 through S1 approach was noted.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**L4-5 Anterior lumbar decompression and fusion with allograft, cage and plate:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

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

**Decision rationale:** The records indicated that the treating physician requested on 09/20/13 an anterior discectomy and fusion at L4-5 and L5-S1 with allograft, cage, and plate that has been noted. It was documented that prior surgery included an L4-5 decompression and fusion and that he now had L5-S1 spondylolisthesis, which was problematic. It is unclear if this diagnosis has been concluded within the records, as I cannot find flexion and extension radiographs, which demonstrate angular or transitional abnormal translation at disc spaces. These records do not clearly delineate a need for L4-5 anterior lumbar decompression and fusion with allograft and they are somewhat conflicting as there is apparent posterior spinal fusion, and no evidence of pseudoarthrosis. Therefore, this request cannot be supported in review of the records available and, also in addition to the adjunctive decision of the assistant surgeon, medical clearance, cold and hot therapy, bone growth stimulator, lumbosacral orthosis and postoperative physical therapy as well as inpatient stay for three days.

**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 Milliman Care Guidelines, Inpatient and Surgical Care, 16th Edition, Assistant Surgeon Tables - lumbar fusion procedure

**Decision rationale:** An assistant surgeon in this setting would be appropriate and supported by guidelines however, a medical necessity for the surgery has not been established.

**Medical clearance:**

**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 Foundation Chapters (ACOEM Practice Guidelines, 2nd Edition (2004)) Independent Medical Evaluation and Consultation.

**Decision rationale:** Guidelines allow for consultation for the determination of medical stability and this would be appropriate prior to undertaking the surgical intervention as performed. In this case however, the medical necessity for the surgery has not been established and as such the medical clearance would not be considered as medically necessary.

**Hot/Cold therapy unit:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints  
Page(s): 298-300.

**Decision rationale:** In cases of back surgery, cryotherapy units are not specifically addressed. Guidelines would allow for the application of cold packs and there would not be a medical necessity for a cryotherapy unit. Additionally, the surgical intervention in this case was not found to be medically necessary.

**Bone growth stimulator:** 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 Official Disability Guidelines (ODG), Low Back Criteria for use of invasive or non-invasive electrical bone growth stimulators.

**Decision rationale:** Bone growth stimulators are supported in cases such as this where there is a prior fusion; however, the medical necessity for the surgery was not established and as such there would not be a medical necessity for the bone growth stimulator.

**LSO back brace:** 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 Official Disability Guidelines (ODG), Low Back - Back Brace, Postoperative

**Decision rationale:** Back braces are considered a reasonable option in the postoperative course for a fusion procedure. In this case however, the medical necessity for the surgery was not established and as such there would not be a medical necessity for the requested back brace.

**Post-operative physical therapy 12 sessions 2 x 6 for low back:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Postsurgical Treatment Guidelines.

**Decision rationale:** The requested physical therapy would be considered as within the allowed guidelines for the fusion procedure that was performed. However as the surgery was not medically necessary there would not be a need for the postoperative physical therapy.

**Three (3) inpatient days:** 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 Official Disability Guidelines (ODG), Low Back - Hospital Length of Stay, Lumbar Fusion, anterior

**Decision rationale:** A 3-day length of stay for the procedure that was done would be supported by guidelines. The surgery however has not been established as medically necessary and as such there would not be a medical necessity for the 3 day inpatient stay.