

<b>Case Number:</b>	CM13-0063388		
<b>Date Assigned:</b>	12/30/2013	<b>Date of Injury:</b>	09/21/2011
<b>Decision Date:</b>	05/12/2014	<b>UR Denial Date:</b>	11/12/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/10/2013

### 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 Surgery, has a subspecialty in Spine Surgery and is licensed to practice in Texas and 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 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 49-year-old male who reported injury on 09/21/2011. The mechanism of injury was the injured worker was pulling heavy boxes from an overhead position and twisted his back. The injured worker indicated a box became stuck and caused him to twist his body, and the injured worker began to fall and caught himself, feeling an immediate pain in his back. The MRI of 01/09/2013 revealed (1) at L4-5, there was a 3 mm posterior disc protrusion/endplate osteophyte complex with a small amount of hyper intensity to signal intensity along the posterior disc margins suspicious for an annular tear, there was minimal effacement of the ventral thecal sac with mild to moderate central canal stenosis, and the disc material contacted and partly effaced the proximal bilateral L5 nerve root, the neural foramina were mildly stenotic bilaterally; (2) at L5-S1, there was a 4 mm broad-based posterior disc protrusion accentuated to the right without evidence of the thecal sac or nerve root effacement, there was a small amount of hyper intensity T2 signal intensity along the posterior disc margin consistent with an annular tear, the neural foramina were mildly stenotic. The interpretation was mild degenerative disc disease at L4-5 and L5-S1. Additionally, it was indicated there were multilevel 3 mm to 4 mm posterior disc protrusions and/or posterior disc protrusion/endplate osteophyte complexes from L2-3 inferiorly through L5-S1 with mild to moderate central canal stenosis and mild bilateral neural foraminal stenosis at L4-5 and L5-S1. The injured worker had a lumbar discogram on 09/23/2013, which revealed, at the level of L5-S1, the discogram was positive for reproduction of 9/10 right low back pain with evidence of posterior annular tear to the other annulus. A CT discogram of the lumbar spine revealed (1) at L4-5, there was mild facet hypertrophy, there was a 2 mm broad-based disc bulge without significant central or foraminal narrowing, there was posterior central annular tear, there was trace contrast extending to the anterior epidural space superiorly to L2-3; (2) at L5-S1, there was contrast noted to be extending into the posterior

annulus, concerning for annular tear, there was no significant interval disc protrusion, central or neural foraminal narrowing. Physical examination dated 10/19/2013 revealed the injured worker had 2+ lumbar paraspinous muscle spasms and tenderness to the muscles. The injured worker had motor strength of 5/5 and the straight leg raise in the seated and supine positions was negative bilaterally. The deep tendon reflexes were 2+ bilaterally for the knees and ankles. The injured worker had decreased range of motion in the lumbar spine in flexion. The diagnosis was internal disc disruption at L4-S1. The recommendation was the injured worker had reached maximum medical benefit from conservative and nonoperative care and was a surgical candidate. It was indicated that the injured worker's discogram showed that 2 other discs, the L4-S1 discs, were the pain generators that correlated with the MRI, showing degenerative disc disease and annular tears at these levels. The recommendation was for an anterior lumbar interbody fusion at L4-S1 to remove the pain generator, which was the disc, and to stabilize the spine with an interbody cage and bone morphogenic protein.

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

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

#### **ANTERIOR LUMBAR INTERBODY FUSION L4-5, L5-S1: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 307. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back Chapter, Fusion.

**Decision rationale:** ACOEM Guidelines indicate that, except for cases of trauma related to spinal fracture or dislocation, fusion of the spine is not considered during the first 3 months of symptoms. Patients with increased spinal instability not work related after surgical decompression at the level of degenerative spondylolisthesis may be a candidate for fusion. There is no scientific evidence about the long-term effectiveness of any form of surgical decompression or fusion for degenerative lumbar spondylosis compared with natural history, placebo, and conservative treatment. Additionally, there is no good evidence from controlled trials that a spinal fusion alone is effective for treating any type of acute low back problems in the absence of spinal fracture, dislocation, or spondylolisthesis if there is instability and motion in the segment that is operated on. However, as they do not specifically address the criteria for a fusion, secondary guidelines were sought. Official Disability Guidelines do not recommend a fusion unless there is objectively demonstrated severe structural instability and/or acute progress or neurologic dysfunction, but it is recommended as an option for spinal fracture, dislocation, spondylolisthesis, or frank neurogenic compromise subject to selection criteria, including neural arch defect, segmental instability objectively demonstrable including excessive motion as in degenerative spondylolisthesis, primary mechanical back pain/instability including 1 level or 2 level segmental failure with progressive degenerative changes, loss of height and disc loading capability, and revision surgery for previous failed operations. Official Disability Guidelines go on to indicate that the clinical surgical indications for a spinal fusion include all pain generators have been identified and treated, all physical medicine and manual therapy interventions are

completed, there are x-rays demonstrating spinal instability and/or myelogram, CT myelogram, or discography and MRI demonstrating disc pathology correlating with symptoms and exam findings, spine pathology is limited to 2 levels, as well as there has been a psychosocial screening with confounding issues addressed, and, for any potential fusion surgery, the injured worker has not smoked for at least 6 weeks prior to the surgery and during the period of fusion healing. The clinical documentation submitted for review failed to indicate the injured worker had x-rays demonstrating instability. There was no indication that the injured worker had a spinal fracture, dislocation, spondylolisthesis, or frank neurogenic compromise including neural arch defect, and segmental instability that was objectively demonstrable. The physical examination revealed the injured worker had a decrease in flexion, with a normal extension. The discogram indicated that the injured worker's range of motion was within normal limits and there was desiccation; however, there was additionally desiccation that was described at other levels of L2-3, which were not included in the procedure. Additionally, the loss of disc height was described as mild. While it was indicated that the injured worker had reached maximal medical benefit from conservative and non-operative treatment, there was a lack of documentation indicating conservative care that was given including physical medicine and manual therapy and the injured worker's response to those treatments. Given the above, the request for anterior lumbar interbody fusion L4-5, L5-S1 is not medically necessary.

**3 DAY INPATIENT STAY: 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.

**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 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 BACK BRACE PURCHASE: 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 PURCHASE: 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 PURCHASE:** 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.

**TENS PURCHASE:** 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.

**HOT/COLD UNIT PURCHASE:** 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.

**FRONT WHEEL WALKER PURCHASE:** 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.

**3 IN 1 COMMODE PURCHASE:** 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.

**POST OPERATIVE HOME HEALTH NURSE FOR DAILY DRESSING CHANGES/  
WOUND CHECK FOR 14 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.