

<b>Case Number:</b>	CM14-0002589		
<b>Date Assigned:</b>	01/24/2014	<b>Date of Injury:</b>	06/10/2010
<b>Decision Date:</b>	06/19/2014	<b>UR Denial Date:</b>	12/26/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/07/2014

### 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 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 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 claimant is a 56-year-old gentleman who sustained a low back injury on June 10, 2010. Specific to the lumbar spine, the reviewed records document evidence of a prior fusion at the L4-5 level, confirmed by a report of a CT scan dated February 7, 2012, that showed evidence of L5-S1 foraminal narrowing. The report of an MRI scan dated October 22, 2012, showed evidence of prior surgery with disc desiccation at the L5-S1 level and foraminal stenosis at L5. A recent progress report dated November 1, 2013, indicated continued complaints of low back pain with radiating right leg pain. Physical examination showed restricted range of motion and strength deficit to the right psoas, anterior tibialis and extensor hallucis longus. Diminished sensation to pinprick was noted in a right L4 through S1 dermatomal distribution. Further clinical imaging was not referenced. This request is for the following: an L5-S1 lumbar fusion to treat the claimant's low back and lower extremity complaints; a one-day inpatient hospital stay; a vascular co-surgeon; preoperative laboratory testing; preoperative medical clearance; preoperative electrocardiogram; preoperative chest radiographs; a lumbar back brace; and a bone growth stimulator.

### IMR ISSUES, DECISIONS AND RATIONALES

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

#### **ANTERIOR LUMBAR INTERBODY FUSION L5, S1: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 308-310.

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

**Decision rationale:** According to the MTUS/ACOEM Guidelines, "Spinal fusion Except for cases of trauma-related spinal fracture or dislocation, fusion of the spine is not usually considered during the first three months of symptoms. Patients with increased spinal instability (not work-related) after surgical decompression at the level of degenerative spondylolisthesis may be candidates 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, or conservative treatment. There is no good evidence from controlled trials that spinal fusion alone is effective for treating any type of acute low back problem, in the absence of spinal fracture, dislocation, or spondylolisthesis if there is instability and motion in the segment operated on. It is important to note that although it is being undertaken, lumbar fusion in patients with other types of low back pain very seldom cures the patient. A recent study has shown that only 29% assessed themselves as "much better" in the surgical group versus 14% "much better" in the non-fusion group (a 15% greater chance of being "much better") versus a 17% complication rate (including 9% life-threatening or reoperation)." In this case, the employee is noted to have stenosis at the L5-S1 level; the reviewed records do not reflect segmental instability that would indicate the need for a fusion procedure. MTUS/ACOEM Guidelines recommend fusion in the presence of instability. With no imaging results documenting dysfunction in segmental motion, the request for spinal fusion has not met the MTUS/ACOEM guidelines. Therefore, the request for anterior lumbar interbody fusion L5-S1 is not medically necessary and appropriate.

**INPATIENT STAY FOR 1 DAY:** 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) Treatment in Worker's Comp, 18th Edition, 2013 Updates: low back procedure - Fusion (spinal).

**Decision rationale:** Non-MTUS Official Disability Guidelines (ODG).

**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 Other Medical Treatment Guideline or Medical Evidence: Milliman Care Guidelines 18th edition.

**Decision rationale:** The request for anterior lumbar interbody fusion at the L5-S1 level is not established as medically necessary. Therefore, the request for a vascular co-surgeon is not medically necessary.

**PREOPERATIVE MEDICAL CONSULTATION:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine, page 127.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) Chapter 7 Independent Medical Examinations and Consultations, page 127.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**LABORATORY TESTING:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Non-MTUS Citation: Official Disability Guidelines (ODG).

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004), Chapter 7 Independent Medical Examinations and Consultations, page 127.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**EKG:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Non-MTUS Citation: Official Disability Guidelines (ODG).

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004), Chapter 7 Independent Medical Examinations and Consultations, page 127.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**CHEST RADIOGRAPH:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Non-MTUS Citation: Official Disability Guidelines (ODG).

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation X American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004), Chapter 7 Independent Medical Examinations and Consultations, page 127.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**LUMBAR BACK BRACE:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints, Postsurgical Treatment Guidelines. Decision based on Non-MTUS Citation Non-MTUS Citation: Official Disability Guidelines (ODG).

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 1 Prevention Page(s): 9.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**BONE GROWTH STIMULATOR FOR PURCHASE WITH IN OFFICE FITTING:**  
Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Non-MTUS Citation: <http://www.bcbsnc.com>.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Treatment in Worker's Comp, 18th Edition, 2013.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.