

<b>Case Number:</b>	CM14-0115407		
<b>Date Assigned:</b>	08/13/2014	<b>Date of Injury:</b>	10/14/2011
<b>Decision Date:</b>	09/18/2014	<b>UR Denial Date:</b>	07/07/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/23/2014

### 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 Surgery 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 45-year-old male who reported injury on 10/14/2011. The injured worker was using a 150 pound Crowder device to guide salmon into the suction area, and the fish were dying due to a lack of oxygen, so the injured worker lifted the Crowder up and felt a pop in his low back. The injured worker underwent an MRI of the lumbar spine, and an x-ray of the lumbar spine. The prior procedures included a bilateral sacroiliac injection and medications, TENS use, E-Stim, as well as physical therapy. The medications were noted to include MS Contin 15 mg twice a day, Percocet 10/325 mg 1 daily, and Baclofen 10 mg 3 time a day. The documentation of 03/12/2014 revealed the injured worker underwent x-rays with no vertebral malalignment, displaced fracture or vertebral compression deformity. There were moderate degenerative changes at L5-S1. The injured worker underwent X-Rays of the lumbar spine on 04/19/2014 which revealed limited range of motion of the lumbar spine, no vertebral instability with flexion or extension, and degenerative changes at L5-S1. The injured worker underwent an MRI of the lumbar spine on 09/12/2013 which revealed the injured worker had mild multilevel degenerative disc disease and degenerative joint disease with some disc bulges, but there was no definite central canal stenosis or peripheral nerve root compression. There were endplate changes at L5-S1, some of which showed edema, which suggested that there might be that there might be an acute process at this level. The disc bulge seemed to be more anterior and not posterior. Therefore, it may cause pain but it is likely not causing nerve root compression. The most recent note dated 06/13/2014 revealed the injured worker was symptomatic and had ongoing severe low back pain with radiation into the anterior thighs and groins. The injured worker was noted to have failed epidural injection therapy as well as physical therapy. The injured worker had a trial of long acting opiates that was being maintained on Percocet, Baclofen and ibuprofen. The treatment plan included an anterior lumbar interbody fusion at L5-S1 as well

as a disc replacement at L4-5, a preoperative medical clearance and a vascular surgeon, and a hybrid disc, as it was noted the injured worker had L5-S1 significant collapse per the MRI. The rationale was that placing the disc replacement on top of a fusion would minimize adjacent segment disease. It was opined placing the disc replacement on top of a fusion would minimize adjacent segment disease at L3-4. Additionally, the request was made for an iliac crest autograft for the fusion at L5-S1.

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

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

#### **Anterior lumbar interbody fusion #1: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 307-309.

**Decision rationale:** The American College of Occupational and Environmental Medicine Guidelines indicate that surgical consultation may be appropriate for injured workers who have severe and disabling lower leg symptoms in a distribution consistent with abnormalities on imaging, preferably with accompanying objective signs of neural compromise, activity limitations due to radiating leg pain for more than 1 month, or the extreme progression of lower leg symptoms, 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 a failure of conservative treatment to resolve disabling radicular symptoms. Additionally, there is no good evidence from control 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 in motion in the segment operated on. Electrodiagnostic studies would not be applicable in this instance. The clinical documentation submitted for review indicated the MRI findings were that the injured worker had a broad based disc bulge and facet arthropathy. There was a lack of documentation indicating central canal stenosis and radiologic evidence of instability. There was no physical examination findings submitted for review. The request for Anterior Lumbar Interbody Fusion (ALIF) L5-S1 QTY: 1.00 is not medically necessary.

#### **Anterior instrumentation: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

**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.

#### **Application of intervertebral biomechanical device: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

**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.

**Disc replacement L4-5:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

**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 Chapter, Disc prosthesis.

**Decision rationale:** The Official Disability Guidelines do not recommend artificial disc replacement. The clinical documentation submitted for review indicated, per the physician, the injured worker had degeneration at L4-5 and L5-S1 with no instability. The request was made for a hybrid, and the rationale was that placing a disc replacement on top of a fusion would minimize adjacent segment disease at L3-4. There was a lack of documented EMG/NCV to support the injured worker had nerve impingement. There was no documentation of nerve impingement findings. There was no physical examination submitted for review. However, the fusion was not supported. There was a lack of documentation of exceptional factors to warrant nonadherence to guideline recommendations. Given the above, the request for Disc replacement L4-5 QTY: 1.00 is not medically necessary.

**Autograft for spine surgery:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

**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.

**Pre-operative medical clearance:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM.

**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:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

**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.

**Iliac crest autograft to be used for fusion L5-S1:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

**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.

**Inpatient Hospital Stay:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM.

**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.