

<b>Case Number:</b>	CM14-0152454		
<b>Date Assigned:</b>	09/22/2014	<b>Date of Injury:</b>	02/04/2014
<b>Decision Date:</b>	10/21/2014	<b>UR Denial Date:</b>	08/27/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/18/2014

### 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:

This 36-year-old male electrician reported an industrial injury on 2/4/14 relative to shoveling and digging a ditch. Initial treatment included physical therapy and medications. Past surgical history was positive for a presumed left L4/5 microdiscectomy for disc herniation in 2000 with full recovery. The 3/17/14 lumbar spine MRI documented the patient was status post left hemi laminectomy at L4/5 with stripping of the left ligamentum flavum. There was a left paraspinal soft tissue structure encroaching into the left lateral recess and abutting the transversing left L5 nerve. This soft tissue structure could represent granulation tissue or disc extrusion, and could not be distinguished without intravenous contrast. The L5/S1 level was reported normal with no significant disc bulge, spinal canal stenosis, or neuroforaminal narrowing. The 5/29/14 lumbar spine MRI with contrast impression documented L4/5 posterior left paracentral disc extrusion with associated annular tear extending down posterior to the L5 superior endplate. This resulted in mild effacement of the anterior left thecal sac and mild left foraminal narrowing. The 8/7/14 orthopedic consult report cited complaints of grade 7/10 low back pain radiating down the left leg into the hamstring. Pain is reported 60% pain and 40% leg. He denied leg numbness or weakness and there was no loss of bowel or bladder function. Pain was aggravated by prolonged sitting, standing, coughing, sneezing, and bending forward. Pain was reduced by lying down and walking. Physical exam documented the patient could ambulate without an antalgic gait and heel/toe walk without difficulty. There was no pain on palpation of the lower spine. No step-off or significant paraspinal muscle spasms were noted. Lumbar range of motion was reduced 50% in forward flexion; other motions were normal. Straight leg raise was positive for left leg pain at 60 degrees. Neurologic exam documented 5/5 strength, normal sensation, and +2 and symmetrical deep tendon reflexes. Prior surgery was noted at L5/S1. The treatment plan recommended an anterior lumbar interbody fusion at L5/S1 for the recurrent disc herniation and

annular tear which was compressing the transiting L5 nerve root. There was significant facet arthropathy. A revision laminotomy would be an option but it would require a significant facetectomy given the previous discectomy and result in iatrogenic instability. The patient did not want an epidural steroid injection as this was just a "Band-Aid", he desired surgical intervention. The 8/7/14 lumbar spine x-rays with flexion and extension views documented mild disc space narrowing at L4/5 and moderate disc space narrowing at L5/S1. An addendum documented there was a transitional lumbosacral vertebra with a 1 mm retrolisthesis one level above the transitional vertebrae. The treating physician labeled the transitional vertebrae S1. The 8/27/14 utilization review denied lumbar surgery and the associated request as there was no evidence of spinal instability or substantial neurologic deficits which would warrant surgery. Additionally, a psychosocial screen with confounding issues addressed was not documented.

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

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

**L5-S1 ALIF:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305, 310. Decision based on Non-MTUS Citation Official Disability Guidelines: Low Back Chapter

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 209-211. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back - Lumbar & Thoracic, Fusion (spinal)

**Decision rationale:** The ACOEM revised low back guidelines state that lumbar fusion is not recommended as a treatment for patients with radiculopathy from disc herniation or for patients with chronic lower back pain after lumbar discectomy. The Official Disability Guidelines (ODG) state that spinal fusion is not recommended for patients who have less than six months of failed recommended conservative care unless there is objectively demonstrated severe structural instability and/or acute or progressive neurologic dysfunction. Fusion is recommended for objectively demonstrable segmental instability, such as excessive motion with degenerative spondylolisthesis. Pre-operative clinical surgical indications require completion of all physical therapy and manual therapy interventions, x-rays demonstrating spinal instability, spine pathology limited to 2 levels, and psychosocial screening with confounding issues addressed. Guideline criteria have not been met. Evidence of 6 months of a reasonable and/or comprehensive non-operative treatment protocol trial and failure has not been submitted. There is no imaging evidence of significant spinal instability or clinical evidence of acute neurologic dysfunction. A psychosocial screen is not evidenced. Therefore, this request is not medically necessary.

**Co-surgeon [REDACTED], anterior approach:** 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: Centers for Medicare and Medicaid services, Physician Fee Schedule

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

**Consult with [REDACTED]:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation CA MTUS 2004 OMPG, Cornerstones of Disability Prevention and Management Chapter 5; page 92 regarding referral CA MTUS 2004 OMPG, Independent Medical Examinations and Consultations Chapter 7 page 127 regarding referrals Official Disability Guidelines: Lumbar Chapter; Office visits

**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: Centers for Medicare and Medicaid services, Physician Fee Schedule

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

**2 Day Inpatient stay:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines: Low Back Chapter; Hospital length of stay (LOS)

**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 - Lumbar & Thoracic, Hospital length of stay (LOS)

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

**Lumbar support:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Low Back Chapter; regarding Lumbar supports

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 138-139.

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

**Bone Growth Stimulator:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines: Lumbar Chapter; Bone growth stimulators (BGS)

**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 - Lumbar & Thoracic, Bone growth stimulators (BGS)

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

**Fitting:** 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): 138-139.

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