

<b>Case Number:</b>	CM14-0021106		
<b>Date Assigned:</b>	05/05/2014	<b>Date of Injury:</b>	06/14/2013
<b>Decision Date:</b>	07/22/2014	<b>UR Denial Date:</b>	01/30/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/20/2014

### 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 Surgeon, 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 injured worker is a 48-year-old male who reported an injury on 06/14/2013. The mechanism of injury was not specifically stated. The current diagnoses are discopathy, spondylolisthesis and pars defect at L5-S1 with a broad-based protrusion and foraminal stenosis. The injured worker was evaluated on 01/17/2014. Physical examination revealed limited lumbar range of motion, muscle spasms, exquisite tenderness, a limping gait, 4/5 strength bilaterally and 2+ deep tendon reflexes with intact sensation. Treatment recommendations at that time included a request for an anterior and posterior lumbar interbody fusion at L5-S1. It is noted that the injured worker underwent a CT scan of the lumbar spine on 12/26/2013, which indicated a subtle, nondisplaced fracture of the left L5 pars interarticularis, anterolisthesis at L5-S1 resulting in bilateral neural foraminal stenosis, mild discogenic disease at L4-5 and degenerative hypertrophic facet arthropathy at L4-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 L5-S1: Overturned**

**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): 305-307. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, Fusion.

**Decision rationale:** The California MTUS/ACOEM Practice Guidelines state a surgical consultation is indicated for patients who have severe and disabling lower extremity symptoms; activity limitations for more than 1 month; extreme progression of lower extremity symptoms; clear clinical, imaging and electrophysiologic evidence of a lesion; and a failure of conservative treatment. The Official Disability Guidelines state that preoperative clinical surgical indications for a spinal fusion should include identification and treatment of all pain generators, completion of all physical medicine and manual therapy interventions, documented instability on x-rays or CT myelogram, spine pathology that is limited to 2 levels and a psychosocial screening with confounding issues addressed. As per the documentation submitted, the injured worker's CT scan of the lumbar spine on 12/26/2013 does indicate anterolisthesis at L5-S1. The injured worker's physical examination does reveal limited range of motion, weakness and positive straight leg raise. The injured worker has been previously treated with physical therapy and 2 epidural steroid injections. Given the injured worker's progression of symptoms despite conservative treatment and imaging findings, the request can be determined as medically appropriate. Therefore, the current request is medically necessary.

**POSTERIOR SPINAL FUSION L5-S1 WITH DECOMPRESSION:** Overturned

**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): 305-307.

**Decision rationale:** The California MTUS/ACOEM Practice Guidelines state a surgical consultation is indicated for patients who have severe and disabling lower extremity symptoms; activity limitations for more than 1 month; extreme progression of lower extremity symptoms; clear clinical, imaging and electrophysiologic evidence of a lesion; and a failure of conservative treatment. The Official Disability Guidelines state that preoperative clinical surgical indications for a spinal fusion should include identification and treatment of all pain generators, completion of all physical medicine and manual therapy interventions, documented instability on x-rays or CT myelogram, spine pathology that is limited to 2 levels and a psychosocial screening with confounding issues addressed. As per the documentation submitted, the injured worker's CT scan of the lumbar spine on 12/26/2013 does indicate anterolisthesis at L5-S1. The injured worker's physical examination does reveal limited range of motion, weakness and positive straight leg raise. The injured worker has been previously treated with physical therapy and 2 epidural steroid injections. Given the injured worker's progression of symptoms despite conservative treatment and imaging findings, the request can be determined as medically appropriate. Therefore, the current request is medically necessary.

**INPATIENT 3-5 DAYS STAY:** 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 Chapter, Hospital Length of Stay.

**Decision rationale:** The Official Disability Guidelines state the hospital length of stay following an anterior and posterior lumbar fusion includes a median of 3 days. Therefore, the current request for an inpatient stay for 3 to 5 days exceeds the guideline recommendations. As such, the request is non-certified.

**VASCULAR SURGEON AND ASSISTANT SURGEON:** Overturned

**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 Chapter, Surgical assistant.

**Decision rationale:** The Official Disability Guidelines state that a surgical assistant is recommended as an option in more complex surgeries. The injured worker has been authorized to undergo an anterior/posterior lumbar interbody fusion. Given the complexity and nature of the procedure with an anterior approach, the current request can be determined as medically appropriate. As such, the request is medically necessary.

**PRE-OP CLEARANCE TO INCLUDE: CBC, CMP, PT, PTT, UA, CHEST- XRAY & EKG:** Overturned

**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 Chapter, Preoperative Testing, General.

**Decision rationale:** The Official Disability Guidelines state that preoperative testing should be guided by the patient's clinical history, comorbidities and physical examination findings. As per the documentation submitted, the injured worker does have a medical history of hypertension and diabetes. Therefore, the current request for preoperative clearance can be determined as medically appropriate given the patient's age and medical history. As such, the request is medically necessary.

**LUMBAR BACK BRACE:** Overturned

**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 Chapter, Back brace, post-operative (fusion).

**Decision rationale:** The Official Disability Guidelines state that a postoperative back brace following a fusion is currently under study; and given the lack of evidence supporting the use of these devices, a standard brace is preferred over a custom postoperative brace. The injured worker has been authorized to undergo an anterior and posterior lumbar interbody fusion with decompression. Therefore, the current request for a postoperative lumbar back brace can be determined as medically appropriate. As such, the request is 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 Chapter, Bone Growth Stimulator.

**Decision rationale:** The Official Disability Guidelines state that either invasive or noninvasive methods of electrical bone growth stimulation may be considered medically necessary as an adjunct to spinal fusion for patients with risk factors for failed fusion, including 1 or more previous failed spinal fusions, grade III or worse spondylolisthesis, fusion to be performed at more than 1 level, a current smoking habit, diabetes, renal disease, alcoholism or significant osteoporosis. The Official Disability Guidelines do not recommend a bone growth stimulator for a single-level fusion. As such, the request is not medically necessary.

**ICELESS COLD COMPRESSION THERAPY X 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 base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck & Upper Back Chapter, Continuous-flow cryotherapy.

**Decision rationale:** The Official Disability Guidelines state that continuous flow cryotherapy for the spine is not recommended. Therefore, the current request cannot be determined as medically appropriate. There is no mention of a contraindication to at-home local applications of heat packs as opposed to a motorized unit. Based on the clinical information received and the Official Disability Guidelines, the request is not medically necessary.