

Case Number:	CM14-0061515		
Date Assigned:	07/09/2014	Date of Injury:	04/08/2002
Decision Date:	08/11/2014	UR Denial Date:	03/31/2014
Priority:	Standard	Application Received:	05/02/2014

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 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 58-year-old male who sustained an injury on 04/08/02 after twisting his low back. The injured worker indicated that he slipped twisting his low back causing pain with without lower extremities symptoms. Prior treatment included anti-inflammatories muscle relaxers and analgesics for pain. The injured worker was seen on 04/04/14 with more than 10 years complaints of low back pain radiating to the bilateral buttocks and into the lower extremities right side worse than left. Distribution of symptoms included the lateral and posterior thigh and anterior lateral and posterior lower leg and top of the right foot. The injured worker denied any subjective weakness in the lower extremities. Symptoms affected his ability to walk without a four-point walker or cane. The injured worker had prior surgical history of lumbar discectomy and had a spinal cord stimulator placed. On physical examination, there was an antalgic and stooped gait. Strength in the lower extremities was intact and reflexes were 1+ at the patella to the right and normal to the left with absent ankle reflexes bilaterally. Abnormal tone was not identified. Recommendation at this visit was for right lateral approach for direct lateral interbody fusion at L3-4 and L4-5 with bone morphogenic protein and interbody spacer. This would be followed by posterior spinal fusion with decompression at L3-4 and L4-5 with removal of the previous spinal cord stimulator. Radiographs of the lumbar spine from 03/04/14 noted severe spondylitic disease at L3-4 and L4-5 with anterior spondylosis and spondylosis posteriorly. There was moderate to severe dorsal loss of disc space height at L5-S1. Computerized tomography (CT) myelogram of the lumbar spine on 03/04/14 noted disc vacuum phenomena with severe spondylitic disease in a 4mm ventral effacement of thecal sac resulting in moderate canal stenosis with crowding of the intrathecal nerve roots. There was amputation of the bilateral L3 nerve root sleeves. At L4-5, there was degenerative disease with severe spondylitic change and endplate sclerosis with 3mm effacement of the ventral thecal sac. There

was mass effect of the right L5 nerve root. Amputation of the bilateral L4 nerve roots was also noted. The requested right L3-4 L4-5 direct lumbar interbody fusion with bone morphogenetic protein posterior spinal fusion from L3 through L5 with bilateral laminectomy foraminotomy and bone morphogenetic protein removal and removal of stimulator with assistant surgeon five day injured worker stay and pre-operative internist was non-certified by utilization review on 03/31/14. Was non-certified by utilization review on an undetermined date.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right L3-4, L4-5 direct lumbar interbody fusion with bone morphogenetic protein (BMP); Posterior spinal fusion of L3-5 & bilateral laminectomy/foraminotomy & bone morphogenetic protein (BMP), removal of stimulator.: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 341-343. Decision based on Non-MTUS Citation Harris J, Occupational Medicine Practice Guidelines, 2nd Edition (2004)- pp343-345; Hegmann K, Occupational Medicine Practice Guidelines, 2nd Ed (2008 Revision)-pp. 1020-1021.

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, Bone Morphogenetic Protein.

Decision rationale: This request is not considered medically necessary. Although there are indications for surgical intervention for this injured worker the use of bone morphogenetic protein posterolaterally would not be supported by clinical literature or guidelines. Food and Drug Administration only supports the use of bone morphogenetic protein at one to two lumbar levels utilizing anterior lumbar interbody approach. The use of bone morphogenetic protein during posterolateral fusion procedures would be considered off label and not medically necessary. Therefore, this request as submitted is not medically necessary. As the clinical documentation submitted for review did not would not support the proposed surgical procedures as medically necessary there would be no requirement for removal of the spinal cord stimulator at this time.

Assistant Surgeon.: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 341-343. Decision based on Non-MTUS Citation Harris J, Occupational Medicine Practice Guidelines, 2nd Edition (2004)- pp343-345; Hegmann K, Occupational Medicine Practice Guidelines, 2nd Ed (2008 Revision)-pp. 1020-1021.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation American Association of Orthopaedics Surgeons Position Statement Reimbursement of the First Assistant at Surgery in Orthopaedics.

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

5 day inpatient stay.: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Harris J, Occupational Medicine Practice Guidelines, 2nd Edition (2004)- pp343-345; Hegmann K, Occupational Medicine Practice Guidelines, 2nd Ed (2008 Revision)-pp. 1020-1021.

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, Hospitalization.

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

Pre-operative Internist.: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Harris J, Occupational Medicine Practice Guidelines, 2nd Edition (2004)- pp343-345; Hegmann K, Occupational Medicine Practice Guidelines, 2nd Ed (2008 Revision)-pp. 1020-1021.

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, Pre-operative testing, general.

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