

<b>Case Number:</b>	CM14-0068741		
<b>Date Assigned:</b>	07/14/2014	<b>Date of Injury:</b>	09/18/2010
<b>Decision Date:</b>	08/11/2014	<b>UR Denial Date:</b>	04/22/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/13/2014

### 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 63-year-old female sustained an industrial injury on 9/18/10, relative to a slip and fall. The patient underwent C5/6 anterior cervical discectomy and fusion on 12/4/13. The 11/19/13 lumbar MRI impression documented multilevel degeneration within the lumbar spine and a mild levoscoliosis. There were disc bulges at L2/3, L3/4, and L5/S1 with mild foraminal narrowing but no significant central canal stenosis. At L4/5, there was a diffuse disc bulge/osteophyte complex measuring up to 3 mm and mild to moderate facet arthropathy. There was severe disc height loss. There was no significant central canal stenosis. There was moderate foraminal narrowing bilaterally. The 2/20/14 spine surgery report indicated assumption of care for the lumbar spine. Review of imaging studies was documented. Surgery was recommended to include anterior lumbar interbody fusion at L4/5 given the complete collapse at that level with associated foraminal stenosis and facet arthropathy. The treatment plan recommended a diagnostic block at L4/5, including the bilateral facet joints, and selective nerve root blocks all at the same time. The 3/10/14 treating physician report cited agreement with the spine surgeon. Subjective findings documented increased lumbar pain. Lumbar exam documented positive bilateral straight leg raise, stiffness, spasms, tenderness, and decreased range of motion. The 4/14/14 spine surgeon report noted denial of the request for diagnostic blocks. The treatment plan documented preceding with surgery at L4/5 to include lumbar interbody fusion at L4/5 with bone morphogenetic protein (BMP). BMP was requested because of her bone quality, age, and the fact that an anterior interbody fusion was requested. Anterior fusion will indirectly decompress the neural foramina at L4/5. The 4/22/14 utilization review denied the request for lumbar fusion based on an absence of clinical exam and electrodiagnostic evidence of radiculopathy, or flexion/extension films documenting instability. There was no documentation of conservative treatment directed to the low back noted.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Anterior Lumbar Interbody Fusion L4-5 with extra, extra small Bone Morphogenetic Proteins (BMP), with Cell Saver:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-307. Decision based on Non-MTUS Citation AETNA Clinical Policy.

**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. Lumbar fusion is not recommended as a treatment for spinal stenosis unless concomitant instability or deformity has been proven. 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. There is no evidence of acute or progressive neurologic dysfunction. There is no radiographic or imaging evidence of segmental instability. A psychosocial clearance is not evident. There is no detailed documentation that recent comprehensive pharmacologic and non-pharmacologic conservative treatment had been tried and failed. Therefore, this request for anterior lumbar interbody fusion L4-5 with extra, extra small bone morphogenetic proteins (BMP), with cell saver is not medically necessary.

**Assistant Surgeon:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation American Association of Orthopedic Surgeons Position Statement Reimbursement of the First Assistant at Surgery in Orthopedics.

**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.

**Vascular Assistant:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation American Association of Orthopedic Surgeons Position Statement Reimbursement of the First Assistant at Surgery in Orthopedics.

**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.

**Cold Therapy Unit:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 160-161.

**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 (ODG): Low Back Chapter; Bone Growth Stimulators (BGS); [http://www.odgtwc.com.odgtwc/Knee\\_files/bcbs\\_bone\\_stim.htm](http://www.odgtwc.com.odgtwc/Knee_files/bcbs_bone_stim.htm).

**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.

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