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| <b>Case Number:</b>   | CM14-0095205 |                              |            |
| <b>Date Assigned:</b> | 07/25/2014   | <b>Date of Injury:</b>       | 10/08/1995 |
| <b>Decision Date:</b> | 08/29/2014   | <b>UR Denial Date:</b>       | 06/02/2014 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 06/23/2014 |

### 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 Orthopaedic 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 41-year-old female sustained an industrial injury on 10/8/95, relative to a slip and fall. The patient was status post L4/5 and L5/S1 fusion with stand-alone BAK cages in 1997. She was involved in a rear-end motor vehicle accident going to physical therapy after surgery with acute worsening of her lower back pain radiating down the right leg. The 3/31/14 initial orthopedic exam cited daily severe pain with associated functional difficulties. Physical exam documented generalized spinal tenderness, moderate loss of lumbar range of motion, and 5/5 lower extremity strength. Sensation was grossly intact, with some dysesthesias to the right leg. Gait was normal, including toe/heel walk and tandem gait. There was no evidence of muscle atrophy. MRIs were reviewed. The patient had RAY cages at L4/5 and L5/S1, fusion status was not able to be confirmed. A bone scan was recommended. The 5/15/13 lumbar bone scan demonstrated mild grade accentuation of tracer uptake in the proximity of the hardware at L5, which indicates inflammation. An indolent infection could not be excluded. The 5/21/14 treating physician progress report cited severe low back pain with some buttock radiation. Exam findings were unchanged. The treating physician opined the patient had a pseudoarthrosis at L4/5. She never had any success from the surgery. Stand-alone cages carried a very high risk rate of pseudoarthrosis and were extremely difficult to diagnose radiographically. A Posterior Fusion with Instrumentation was recommended. The 6/2/14 utilization review denied the request for L4/5 Posterior Fusion with Instrumentation and associated durable medical equipment/services based on lack of radiographic evidence of pseudoarthrosis and no CT scan to assess fusion mass. Infection had not been ruled-out prior to implanting hardware. Peer-review conversation was noted with agreement for additional testing.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**L4-5 Posterior Fusion w/ Instrumentation: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. 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 do not address revision surgeries. 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." Revision surgery for a failed previous operation is recommended if significant functional gains are anticipated. 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. Imaging noted inflammation at the L5 hardware site and infection could not be ruled out. There is no evidence that infection has been ruled out, nor is there any clear evidence of pseudoarthrosis. A CT scan was recommended to assess the fusion mass and there is no documentation that this was obtained. There is no detailed documentation that recent comprehensive pharmacologic and non-pharmacologic conservative treatment had been tried and failed nor is there any evidence of segmental instability. A psychosocial screen is not evidenced. Therefore, this request for L4/5 Posterior Fusion with Instrumentation is not medically necessary.

**Intraoperative Neurophysiological Monitoring: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines Intraoperative Neurophysiological Monitoring.

**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, Intraoperative neurophysiological monitoring (during surgery).

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

**Lumbar Brace: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. 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): 138-139.

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

**Orthofix 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 Bone Growth Stimulators Post operative.

**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.

**Vascutherm Cold Therapy Unit- Post Op:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines Cryotherapy with the use of Vasocompression Knee & Leg 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.