

Case Number:	CM13-0035780		
Date Assigned:	12/13/2013	Date of Injury:	04/16/2012
Decision Date:	04/21/2015	UR Denial Date:	09/19/2013
Priority:	Standard	Application Received:	10/17/2013

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
 State(s) of Licensure: Illinois, California, Texas
 Certification(s)/Specialty: Orthopedic Surgery

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 50-year-old male who sustained an industrial injury on 4/16/12. Injury occurred while he was lifting an air conditioner unit up a wall with a rope. X-rays dated 10/26/12 showed possible compression fracture at T12 as well as spondylosis and mild retrolisthesis at L4-5 (3.4 mm) and L5-S1 (3 mm). The 12/11/12 lumbar spine MRI findings documented mild to moderate central stenosis at L4/5 secondary to broad-based posterior disc protrusion/extrusion causing pressure on the thecal sac, and mild pressure over the right L5 and L4 nerve roots. Part of the extruded disc was noted to be extending cephalad posterior in the body of L4. At L5/S1, there was disc desiccation with a 3 mm central posterior disc/endplate osteophyte complex making contact with the anterior aspect of the thecal sac. The 6/21/13 agreed medical examiner report cited low back and right leg pain. Lumbar spine exam documented 4/5 right extensor hallucis longus strength, decreased sensation along the dorsal aspect of the right foot, and symmetrical 2/4 deep tendon reflexes. The diagnosis included lumbar musculoligamentous sprain/strain, and L4/5 extruded disc and central canal stenosis. X-rays revealed overall normal bony alignment of the lumbar spine, moderate disc space narrowing at L5/S1, and mild disc space narrowing at L4/5. There was some mild anterior longitudinal ligament spurring at these levels. The AME supported surgical decompression at L4/5, but opined the need for smoking cessation if the treating physician report was to proceed with a fusion. The 8/19/13 treating physician report cited significant lower back pain. The patient had quit smoking and had not smoked in 2 months. Physical exam was reported unchanged. The 9/19/13 utilization review denied the request for ALIF L4/5 and L5/S1 and PSF/I L4-S1, as there was no documented

segmental instability or unstable spondylolisthesis. The associated surgery requests were non-certified as the surgery was not medically necessary.

IMR ISSUES, DECISIONS AND RATIONALES

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

ALIF L4-5, L5-S1, PSF/I L4-S1 Infuse: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-307.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 307. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Lumbar & Thoracic: Fusion (spinal); Infuse bone graft; Bone-morphogenetic protein (BMP).

Decision rationale: The California MTUS guidelines indicate that lumbar spinal fusion may be considered for patients with increased spinal instability after surgical decompression at the level of degenerative spondylolisthesis. Guidelines state there was no good evidence that spinal fusion alone was effective for treating any type of acute low back problem, in the absence of spinal fracture, dislocation, or spondylolisthesis if there was instability and motion in the segment operated on. 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. The ODG does not recommend the use of Infuse bone graft/bone morphogenetic protein (BMP). Guidelines state there is a lack of clear evidence of improved outcomes with BMP, and there is inadequate evidence of safety and efficacy to support routine use. Guideline criteria have not been met. This patient presents with radicular low back pain that has failed to respond to at least 6 months of reasonable conservative treatment. Clinical exam findings are consistent with imaging evidence of disc extrusion and nerve root compression at L4 and L5. Smoking cessation for 2 months was confirmed. However, there is no imaging evidence of spinal segmental instability or documentation that wide decompression will be required and result in temporary intraoperative instability. A psychosocial screen is not evidenced. There is no compelling reason presented to support the medical necessity of bone morphogenetic proteins over iliac crest autograft or cadaveric allograft for this patient. Therefore, this request is not medically necessary.

Lumbar Back Brace: 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) Treatment Index, 11th Edition (web), 2013, Low Back, Back Support, Fusion.

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: Lumbar supports and Other Medical Treatment Guidelines American College of Occupational and Environmental Medicine (ACOEM). Occupational Medical Practice Guidelines 2nd Edition. Chapter 12 Low Back Disorders. (Revised 2007) page(s) 138-139.

Decision rationale: As the surgical request is not supported, this request is not 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 Lumbar & Thoracic Bone growth stimulators (BGS).

Decision rationale: As the surgical request is not supported, this request is not medically necessary.

Inpatient Stay (2-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) Low Back Lumbar & Thoracic: Hospital length of stay (LOS).

Decision rationale: As the surgical request is not supported, this request is not medically necessary.

Pre-Operative Medical Clearance (Labs, Chest X-Ray, EKG): 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 Lumbar & Thoracic: Preoperative testing, general; Preoperative lab testing; Preoperative electrocardiogram (ECG).

Decision rationale: As the surgical request is not supported, this request is not medically necessary.

Co-Surgeon (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 Official Disability Guidelines (ODG) Low Back Lumbar & Thoracic: Surgical assistant.

Decision rationale: As the surgical request is not supported, this request is not medically necessary.

Consult with Co-Surgeon: 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): 305-306.

Decision rationale: As the surgical request is not supported, this request is not medically necessary.

Assistant Surgeon: 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 Lumbar & Thoracic: Surgical assistant.

Decision rationale: As the surgical request is not supported, this request is not medically necessary.