

<b>Case Number:</b>	CM14-0107758		
<b>Date Assigned:</b>	08/08/2014	<b>Date of Injury:</b>	04/22/2007
<b>Decision Date:</b>	05/01/2015	<b>UR Denial Date:</b>	07/01/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/11/2014

### 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. 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: 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 48-year-old male who reported an injury on 04/22/2007 and 01/23/2007. The mechanism of injury was reaching into the trunk of his car when his legs gave out. His diagnoses included lumbar discopathy and internal derangement of the left knee. His past treatments have included activity modification, physical therapy, pain management, and lumbar epidural block. Diagnostic studies have included an MRI of the lumbar spine on 10/28/2013; x-rays of the lumbar spine were also performed. His surgical history included an anterior cervical spine discectomy and fusion from C5-7. The injured worker had complaint of chronic low back pain. On physical exam, cervical spine has full range of motion. The lumbar spine had tenderness from the mid to distal lumbar segments. There was pain with terminal motion. Seated nerve root test is positive. There is weakness of the ankles and toes. He had progressive neurologic deficit in the lower extremities, the right side greater than the left, with giving away of his legs and dragging his feet. His medications were not included. His treatment plan included discussion of surgery, an L4-S1 posterior lumbar interbody fusion with possible reduction of listhesis. The rationale for the request included pain control and improvement in his the injured worker's activities of daily living. The Request for Authorization form was signed and dated 02/06/2014 in the medical record.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**L4-S1 Posterior lumbar interbody fusion with instrumentation, neural decompression and iliac crest marrow aspiration/harvesting possible junctional levels: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 307. Decision based on Non-MTUS Citation ODG-TWC Low Back Procedure Summary last updated 05/12/14.

**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, Fusion (spinal).

**Decision rationale:** The request for L4-S1 posterior lumbar interbody fusion with instrumentation, neural decompression and iliac crest marrow aspiration/harvesting possible junctional levels is not medically necessary. The Official Disability Guidelines indicate criteria for lumbar spinal fusion and preoperative surgical indications. The MRI findings indicate disc protrusions at L4-5 and L5-S1 with encroachment on the right foramen with compromise of the exiting right nerve root. There was no compromise on the exiting left nerve root. At L5-S1, there is encroachment on the epidural fat. There is no compromise on the traversing nerve roots. The encroachment on the foramina bilaterally with compromise on the exiting nerve roots bilaterally. The actual electrodiagnostic testing report and x-ray report were not submitted with this review. The guidelines indicate that x-rays demonstrating spinal instability and/or myelogram, CT myelogram, or discography and MRI demonstrating disc pathology correlated with symptoms and exam findings are part of the preoperative surgical indications. The clinical documentation and the MRI findings do not correlate. The AME report indicates there was a discogram recommended and there was a lack of documentation that that discogram has been performed. Therefore, the preoperative surgical indications have not been met for a spinal fusion. The request for L4-S1 posterior lumbar interbody fusion with instrumentation, neural decompression and iliac crest marrow aspiration/harvesting possible junctional levels is not medically necessary.

**Front Wheel Walker: 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) Knee and Leg, Walking aids (canes, crutches, braces, orthoses, & walkers).

**Decision rationale:** The request for front wheeled walker is not medically necessary. The request for spinal fusion was not medically necessary. As this request was made as a postoperative request, and although the Official Disability Guidelines recommend walking aids, because the surgery was not supported, the request for front wheeled walker is not medically necessary.

**Ice unit: 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) Knee and Leg, Continuous-flow cryotherapy.

**Decision rationale:** The request for ice unit is not medically necessary. Without approval of surgery, the need for postoperative ice unit is not supported. The Official Disability Guidelines state that continuous flow cryotherapy is recommended as an option after surgery for up to 7 days, including home use. However, as the proposed surgery was not supported, the request for ice unit is not medically necessary.

**Bone 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, Bone growth stimulators (BGS).

**Decision rationale:** The request for bone stimulator is not medically necessary. As the surgery was not approved, the need for postoperative bone stimulator is not supported. The Official Disability Guidelines state the criteria for use of invasive or noninvasive electrical bone growth stimulators may be considered medically necessary with any of the following risk factors for failed fusion: (1) One or more previous failed spinal fusions; (2) Grade 3 or worse spondylolisthesis; (3) Fusion to be performed at more than 1 level; (4) Current smoking habit; (5) Diabetes, renal disease, alcoholism; or, (6) Significant osteoporosis which has been demonstrated on radiographs. However, as the proposed surgery was not approved, the need for the bone stimulator postoperatively is not supported. Therefore, the request for bone stimulator is not medically necessary.

**TLSO:** 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, Back brace, post operative (fusion).

**Decision rationale:** The request for TLSO is not medically necessary. The requested surgery was not approved. Therefore, the request for TLSO postoperatively is not supported. The Official Disability Guidelines state that the use of postoperative back brace after a fusion is

under study, but given the lack of evidence supporting the use of these devices, a standard brace would be preferred over a custom postoperative brace, if any, depending on the experience and expertise of the treating physician. However, as the requested surgery was not approved, the need for postoperative TLSO is not supported. Therefore, the request for TLSO is not medically necessary.

### **3-1 Commode: 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) Knee and leg, Durable medical equipment (DME).

**Decision rationale:** The request for 3 in 1 commode is not medically necessary. As the proposed surgery was not approved, the need for postoperative 3 in 1 commode is not supported. However, the Official Disability Guidelines state that commode chairs are medically necessary if the patient is bed or room confined. Therefore, as the request for surgery was not supported, the request for 3 in 1 commode 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, Surgical assistant.

**Decision rationale:** The request for assistant surgeon is not medically necessary. As the proposed surgery was not approved, the need for an assistant surgeon is not supported by the guidelines. However, the Official Disability Guidelines do state that an assistant surgeon is recommended as an option in more complex surgeries. As the surgery itself was not approved, the need for assistant surgeon is not medically necessary.

### **Medical Clearance: 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, Preoperative testing, general.

**Decision rationale:** The request for medical clearance is not medically necessary. The requested surgery related to this request was not approved; therefore, the need for preoperative medical clearance is not supported by the guidelines. However, the Official Disability Guidelines do state that preoperatively, patients with risk factors should be evaluated with appropriate testing. As the requested surgery was not approved, the request for medical clearance is not medically necessary.

**3 days Inpatient 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, Hospital length of stay (LOS).

**Decision rationale:** The request for 3 days inpatient stay is not medically necessary. As the requested surgery was not approved, the request for 3 days inpatient stay is not supported by the guidelines. However, the Official Disability Guidelines state that for a posterior lumbar fusion, the best target date with no complications for hospital stay is 3 days. As the surgery itself was not approved the request for 3 days inpatient stay is not medically necessary.