

<b>Case Number:</b>	CM14-0096113		
<b>Date Assigned:</b>	08/13/2014	<b>Date of Injury:</b>	12/03/2005
<b>Decision Date:</b>	10/15/2014	<b>UR Denial Date:</b>	05/28/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/24/2014

### 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 is a 45-year-old with a December 3, 2005 injury date. The mechanism of injury is a fall after her right knee gave out. In a follow-up on April 11, 2014, the patient has complaints of severe pain. She continues to fall when her legs give out on her. Objective findings included a healed surgical incision with spasm, painful and limited lumbar range of motion, positive straight leg raise bilaterally occurring at 60 degrees on the right and 70 degrees on the left, and 4/5 quad weakness bilaterally. In a March 21, 2014 note, the provider indicates the results of a lower extremity EMG/NCV study (January 11, 2012), a lumbar spine MRI (May 8, 2013), and a lumbar discogram (September 27, 2013). The EMG/NCV study showed evidence of chronic right L5 radiculopathy. The lumbar MRI showed prior laminectomy at L4-5 and L5-S1 with interbody fusions and posterolateral hardware, minor annular bulge at L3-4 with small protrusion on the left far laterally, and mild central canal stenosis with mild left neural foraminal narrowing and slight posterolateral displacement of exiting left L3 nerve root. The lumbar discogram was positive for pain at L3-4. A lumbar spine MRI on June 6, 2012 showed L3-4 narrowing of bilateral lateral recesses with effacement of the left and right transitioning nerve roots, and fusion of L4-5. Diagnostic impression: s/p lumbar fusion, right L4 symptomatic hardware, lumbar disc disease. Treatment to date: TENS unit, activity modification, medications, injections, physical therapy, posterior lumbar decompression and fusion at L4-S1 (January 21, 2011). A UR decision on May 28, 2014 denied the request for revision L3-4 posterior lumbar interbody fusion on the basis that there was no documentation of subjective and objective radicular findings in the requested nerve root distribution. The request for L4-5 hardware removal was denied because there was a lack of requisite documentation of imaging findings showing failure of hardware fusion, mechanical impingement, or diagnostic hardware injection. The requests for assistant surgeon, neuromonitoring, cell saver, bone growth stimulator, 3-day inpatient stay, preop

medical clearance, walker, brace, and raised toilet seat were denied because they are for intra- or post-op use and the surgical procedure was not certified.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

#### **Revision L3-L4 fusion posteriorly with posterior lumbar interbody fusion (PLIF) with graft instrumentation: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-306. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back Chapter

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG): Low Back Chapter.

**Decision rationale:** The Low Back Complaints Chapter of the American College of Occupational and Environmental Medicine (ACOEM) Practice Guidelines states that there is no good evidence from controlled trials that spinal fusion alone is effective for treating any type of acute low back problem, in the absence of spinal fracture, dislocation, or spondylolisthesis if there is instability and motion in the segment operated on. ODG states that, until further research is conducted there remains insufficient evidence to recommend fusion for chronic low back pain in the absence of stenosis and spondylolisthesis, and this treatment for this condition remains "under study." It appears that workers' compensation populations require particular scrutiny when being considered for fusion for chronic low back pain, as there is evidence of poorer outcomes in subgroups of patients who were receiving compensation or involved in litigation. In the present case, the main issue is that there is no evidence of spinal instability at L3-4. There are no imaging reports in the available documentation, the providers do not refer to any lumbar flexion/extension xray views, and the references to lumbar MRIs do not indicate any evidence of degenerative spondylolisthesis. In addition, the documentation of subjective complaints and objective exam findings is quite limited and nonspecific, such that it is difficult to corroborate those findings together and with imaging findings so that precise locations of radicular dysfunction can be determined. A psychological clearance was not obtained. Without more information the proposed surgery cannot be certified at this time. Therefore, the request for revision L3-L4 fusion posteriorly with posterior lumbar interbody fusion (PLIF) with graft instrumentation is not medically necessary or appropriate.

#### **Hardware removal at L4-L5: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back Chapter

**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.

**Decision rationale:** CA MTUS does not address this issue. The ODG states that if a hardware injection can eliminate the pain by reducing the swelling and inflammation near the hardware, the surgeon may decide to remove the patient's hardware. In the present case, there is not documentation that suggests that the current hardware is causing a problem in this patient. There is no rationale that justifies why the hardware needs to be removed, including findings of hardware breakage, failure of fusion, or mechanical impingement. In addition, the principle surgical procedure was not certified. Therefore, the request for hardware removal at L4-5 is not medically necessary or appropriate.

**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 Other Medical Treatment Guideline or Medical Evidence: American Academy of Orthopedic Surgeons (AAOS).

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

**Neuromonitoring:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Web site (<http://emedicine.medscape.com/article/1137763-overview>)

**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.

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

**Cell Saver:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Aetna Clinical Policy

**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: Aetna Clinical Policy Autotransfusers.

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

**Walker:** Overturned

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation The Medicare National Coverage Determinations Manual

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG): Knee Chapter. Other Medical Treatment Guideline or Medical Evidence: Medicare National Coverage Determination Manual.

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

**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, Low Back Chapter, page 301

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 301. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG): Low Back Chapter.

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

**Raised toilet seat:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation The Medicare National Coverage Determinations Manual

**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 Chapter.

**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, Neck & Upper Back Chapters, Bone Growth Simulators (BGS)

**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.

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

**Preoperative Medical Clearance:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back Chapter, Preoperative testing

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG): ODG (Low Back - Lumbar & Thoracic (Acute & Chronic) Chapter-Pre operative EKG and Lab testing) Other Medical Treatment Guideline or Medical Evidence: ACC/AHA 2007 Guidelines on perioperative cardiovascular evaluation and care for noncardiac surgery

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

**3 day inpatient stay:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back Chapter, Hospital length of stay (LOS)

**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.

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