

<b>Case Number:</b>	CM13-0069298		
<b>Date Assigned:</b>	01/03/2014	<b>Date of Injury:</b>	01/06/2010
<b>Decision Date:</b>	08/21/2015	<b>UR Denial Date:</b>	11/25/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/20/2013

### 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:

This injured worker is a 50-year-old female who sustained an industrial injury on 1/6/10 relative to continuous trauma as a deputy sheriff. Conservative treatment had included physical therapy, epidural steroid injections, activity modification, and medications. The 8/2/13 lumbar spine MRI documented a 2 mm disc protrusion/bulge with right neuroforaminal narrowing at L3/4, a 3-4 mm disc protrusion with bilateral neuroforaminal narrowing at L4/5, and a 3 mm disc bulge at L5/S1 with bilateral neuroforaminal narrowing and bilateral facet arthropathy. At L5/S1, there was encroachment on the thecal sac and bilateral foramina with compromise of the exiting right nerve root and to a lesser degree the left nerve root. At L5/S1, there was encroachment on the epidural fat and foramina with compromise of the exiting nerve roots bilaterally. There was a reported levoscoliosis with maintained lordosis and alignment. The 9/6/13 lumbar discogram was reported positive at L4/5 with severe concordant low back pain associated with moderate disc degeneration, and positive at L5/S1 with moderate concordant low back pain associated with moderate disc degeneration. The 10/14/13 treating physician report cited continued lumbar spine symptomatology with progressive neurologic deficit. Lumbar discogram was positive L4 to S1. She had failed all conservative measures, including activity modification, physical therapy, and pain management. Physical exam documented lumbar paravertebral muscle tenderness, guarded and restricted flexion and extension, pain with terminal motion, positive seated nerve root test, dysesthesia at the L5 and S1 dermatomes, and 3+ to 4-/5 motor strength. The injured worker reported dragging her feet and giving way of her legs, consistent with possible foot drop. The treatment plan recommends surgical intervention in the form of L4 to S1 posterior lumbar interbody fusion with realignment of the junctional kyphotic deformity that was present. There appeared to be a component of instability. Authorization was requested for bilateral L4-S1 posterior lumbar interbody fusion with instrumentation, neural decompression and iliac crest marrow aspiration/harvesting, possible junctional levels, ice unit purchase, and

a 3 in 1 commode. The 11/25/13 utilization review partially certified the surgical request to include bilateral L4 to S1 posterior lumbar interbody fusion with instrumentation, neural compression, and iliac crest marrow aspiration/harvesting as the medically necessary for a procedure at the junctional levels was not established as there was no radiographic or exam evidence suggestive of possible proximal level issues. The request for an ice unit purchase was non-certified as there was no guideline support for specialized equipment for the provision of cold therapy in the low back. The request for 3-1 commode purchase was non-certified as there was no associated contraindication that would require the use of the commode.

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

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

**Bilateral 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.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-307. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back, Lumbar & Thoracic, Discectomy/Laminectomy; Fusion (spinal).

**Decision rationale:** The California MTUS recommend surgical consideration when there is severe and disabling lower leg symptoms in a distribution consistent with abnormalities on imaging studies (radiculopathy), preferably with accompanying objective signs of neural compromise. Guidelines require clear clinical, imaging and electrophysiologic evidence of a lesion that has been shown to benefit both in the short term and long term from surgical repair. The guidelines recommend that clinicians consider referral for psychological screening to improve surgical outcomes. The Official Disability Guidelines recommend criteria for lumbar discectomy that include symptoms/findings that confirm the presence of radiculopathy and correlate with clinical exam and imaging findings. The Official Disability Guidelines do not recommend lumbar fusion for patients with degenerative disc disease, disc herniation, spinal stenosis without degenerative spondylolisthesis or instability, or non-specific low back pain. Fusion may be supported for segmental instability (objectively demonstrable) including excessive motion, as in isthmic or degenerative spondylolisthesis, surgically induced segmental instability and mechanical intervertebral collapse of the motion segment and advanced degenerative changes after surgical discectomy. Pre-operative clinical surgical indications include all of the following: (1) All physical medicine and manual therapy interventions are completed with documentation of reasonable patient participation with rehabilitation efforts including skilled therapy visits, and performance of home exercise program during and after formal therapy. Physical medicine and manual therapy interventions should include cognitive behavioral advice (e.g. ordinary activities are not harmful to the back, patients should remain active, etc.); (2) X-rays demonstrating spinal instability and/or myelogram, CT-myelogram, or MRI demonstrating nerve root impingement correlated with symptoms and exam findings; (3) Spine fusion to be performed at one or two levels; (4) Psychosocial screen with confounding issues addressed; the evaluating mental health professional should document the presence and/or absence of identified psychological barriers that are known to preclude post-operative recovery; (5) Smoking cessation for at least six weeks prior to surgery and during the period of fusion healing; (6) There should be documentation that the surgeon has discussed potential alternatives,

benefits and risks of fusion with the patient. This injured worker presents with continued radicular low back pain and progressive neurologic deficit. Clinical exam findings are consistent with imaging evidence of nerve root compression at the L4/5 and L5/S1 levels. A component of instability was reported by the treating physician. Detailed evidence of a recent, reasonable and/or comprehensive non-operative treatment protocol trial and failure has been submitted. The 11/25/13 utilization review partially certified this request to include bilateral L4 to S1 posterior lumbar interbody fusion with instrumentation, neural compression, and iliac crest marrow aspiration/harvesting. The request for surgery at possible junctional levels was non-certified as there was no radiographic or exam evidence suggestive of proximal level issues. There is no additional or compelling information submitted to support the medical necessity of surgery at possible junctional levels. Therefore, this request is not medically necessary.

**Associated surgical service: 3 in 1 commode: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Blue Cross of California, Medical Policy, Durable Medical Equipment (CG-DME-10) and CMS Medicare Benefit Policy manual, Chapter 15, Section 110.1.

**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 California MTUS is silent regarding this durable medical equipment. The Official Disability Guidelines state that certain DME toilet items (commodes) are medically necessary if the patient is room-confined or when prescribed as part of a medical treatment plan for injury or conditions that result in physical limitations. The use of a 3-in-1 commode following multilevel lumbar fusion is reasonable for expected physical limitations and to allow for early functional independence. Therefore, this request is medically necessary.

**Associated surgical service: Ice Unit purchase: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back Procedure Summary (last updated 05/10/2013), Cold /Heat Packs.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 299. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), Occupational Medical Practice Guidelines, Chapter 12 Low Back Disorders (Revised 2007), Hot and cold therapies, pages 160-161.

**Decision rationale:** The California MTUS are silent regarding cold therapy devices, but recommend at home applications of cold packs. The ACOEM Revised Low Back Disorder Guidelines state that the routine use of high-tech devices for cold therapy is not recommended in the treatment of lower back pain. Guidelines support the use of cold packs for patients with low back complaints. Guideline criteria have not been met. There is no compelling reason submitted to support the medical necessity of purchase of an ice unit in the absence of guideline support. Therefore, this request is not medically necessary.