

<b>Case Number:</b>	CM14-0216798		
<b>Date Assigned:</b>	01/06/2015	<b>Date of Injury:</b>	03/18/2008
<b>Decision Date:</b>	03/06/2015	<b>UR Denial Date:</b>	12/03/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/26/2014

### 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: California

Certification(s)/Specialty: Orthopedic Surgery, Sports Medicine

### 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 77-year-old male who reported an injury on 03/18/2008. The mechanism of injury occurred while he was riding the elevator in the parking garage and the power was shut off and the elevator dropped to the basement level from the sixth floor. The injured worker states he experience a loss of consciousness. His relevant diagnoses included lumbar stenosis, lumbar radiculopathy, and back pain. His past treatment includes epidural steroid injections, medications, physical therapy, chiropractic therapy, and lumbar support brace. Pertinent diagnostic studies included an x-ray report performed on 05/17/2012 of the right wrist with findings of no fracture or bone destruction; mild osteoarthritis at the first carpal metacarpal joint and a long distal carpal row; right finger impression: no fracture or bone destruction; and an official MRI of the lumbar spine performed on 04/05/2008 which revealed at the L5-S1 bilateral pars interarticularis defects are associated with grade 1 anterolisthesis of L5 on S1; severe stenosis of the foramen is noted at L5-S1; compression of the L5 nerve root in the foramina is noted. His surgical history was noncontributory. The injured worker presented on 11/18/2014 following an epidural steroid injection at the L5-S1 level which temporarily helped his pain, but now his pain has significantly returned. The injured worker is complaining of severe low back pain with radiculopathy. His exam is unchanged from his prior visit. The clinical states that an MRI shows collapse of the L5-S1 disc space with foraminal stenosis. There were no objective physical examination findings included in the documentation of the clinical note on 11/18/2014. His current medications were not included in the documentation submitted for review. The treatment plan included to proceed with an L5-S1 anterior lumbar interbody fusion. The rationale

for the request was that the injured worker had failed the epidural steroid injection. The injured worker wished to proceed with the surgery. A Request for Authorization for an L5-S1 anterior interbody fusion dated 11/24/2014 was provided within the documentation submitted for review.

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

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

#### **L5-S1 Anterior Interbody Fusion: 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): 305-306. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back, Spinal Fusion.

**Decision rationale:** The request for L5-S1 Anterior Interbody Fusion is not medically necessary. The injured worker has chronic low back pain. The California MTUS/ACOEM Guidelines recommend surgical consultation for patients who have severe/disabling lower extremity symptoms consistent with abnormalities on imaging studies indicating radiculopathy. Additionally, the guidelines for preoperative surgical indications recommend that for spinal fusion all of the following must be included: all pain generators are identified and treated; all physical medicine and manual therapy interventions are included; x-rays demonstrate a spinal instability and/or myelogram, CT myelogram or discography and MRI demonstrating disc pathology correlating with symptoms and exam findings; an spine pathology limited to 2 levels; and psychosocial screen with confounding issues addressed. While, the documentation submitted for review included magnetic resonance imaging, it did not provide evidence of symptoms found on the examination of 11/18/2014. Furthermore, there was no psychosocial screen included with the documentation submitted for review. Given the above, the request for L5-S1 Anterior Interbody Fusion does not support the evidence based guidelines. As such the request for L5-S1 Anterior Interbody Fusion is not medically necessary.

#### **Allograft: 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, Transplantation, intervertebral disc.

**Decision rationale:** The request for Allograft is not medically necessary. The injured worker has chronic low back pain. The Official Disability Guidelines do not recommend transplantation of intervertebral disc until further research is completed. As this treatment is not recommended

by the guidelines, this request is not supported by the guidelines. As such, the request for Allograft is not medically necessary.

**Autograft:** 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, Transplantation, intervertebral disc.

**Decision rationale:** The request for autograft is not medically necessary. The injured worker has chronic low back pain. The Official Disability Guidelines do not recommend transplantation until further research is completed. It is still investigational. As this treatment is not recommended by the guidelines, the requested service is not recommended by the guidelines. As such, the request for autograft is not medically necessary.

**Associated surgical service: 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, ODG hospital length of stay (LOS) guidelines, Lumbar Fusion.

**Decision rationale:** The request for associated surgical service: inpatient stay (2 days) is not medically necessary. The injured worker has chronic low back pain. The Official Disability Guidelines recommend 3 inpatient stay days for an anterior lumbar fusion. However, the documentation submitted for review failed to provide evidence to establish the medical necessity for an L5-S1 anterior interbody fusion. As the L5-S1 anterior interbody fusion did not meet medical necessity, the request for associated surgical service: inpatient stay (2 days) is not medically necessary. As such, the request for associated surgical service: inpatient stay (2 days) is not medically necessary.