

<b>Case Number:</b>	CM14-0218078		
<b>Date Assigned:</b>	01/07/2015	<b>Date of Injury:</b>	05/14/2013
<b>Decision Date:</b>	03/13/2015	<b>UR Denial Date:</b>	12/26/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/29/2014

### 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

### 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 33 year old male who suffered an industrial related injury on 5/14/13 while lifting a box. A physician's report dated 5/21/14 noted the injured worker had complaints of low back pain with numbness, tingling, weakness, stiffness, and decreased or limited range of motion. Headaches, sleeplessness, anxiety, fatigue, and depression were also noted. Diagnoses were noted to be lumbar spine musculoligamentous injury with discopathy, lumbar spine herniated nucleus pulposus, discogenic low back pain, and lumbar spine sprain and strain. The treating physician's report dated 12/8/14 noted new complaints of bilateral leg pain when crossing either leg. The injured worker was taking Norco and Flexeril. Physical examination findings included muscle strength was 5/5 for all groups of the lower extremities, moderate tenderness to palpation of the back. Tension signs were negative, sensation was intact in all dermatomes, and no pathologic reflexes were noted. Range of motion in the back was unchanged significantly. The impression was of low back pain with lumbar degenerative disc disease status post disc herniation at L5-S1. The injured worker was on modified duty. Surgical treatment was recommended. On 12/26/14 the utilization review (UR) physician denied the requests for anterior posterior instrumentation and fusion at L5-S1 with allo graft, inpatient hospitalization, medical clearance, assistant surgeon, and a pre-admit physical therapy evaluation. The UR physician noted the Medical Treatment Utilization Schedule guidelines/Official Disability Guidelines note that prior to consideration of surgical fusion all conservative therapy should have been exhausted and all pain generators should be identified. The injured worker was diagnosed with degenerative disc disease at L5-S1. There was no note of translational spinal

instability. There was no note of pars defects. There was no note of the current course of rehabilitation including core truncal strengthening and a home exercise program. There was no clear benefit for the planned surgery. Therefore the request was denied. Due to the non-certification of the surgery the associated services were also non-certified.

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

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

#### **Anterior posterior instrumentation and fusion L5-S1 with allo graft: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 307. Decision based on Non-MTUS Citation ACOEM Chapter 7 page 7 Official Disability Guidelines - Lumbar spine AACS and ACC/AHA 2007 Guidelines

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 307. Decision based on Non-MTUS Citation Low Back, Fusion

**Decision rationale:** The ACOEM Guidelines Chapter 12 Low Back Complaints page 307 state that lumbar fusion, "Except for cases of trauma-related spinal fracture or dislocation, fusion of the spine is not usually considered during the first three months of symptoms. Patients with increased spinal instability (not work-related) after surgical decompression at the level of degenerative spondylolisthesis may be candidates for fusion." According to the ODG, Low back, Fusion (spinal) should be considered for 6 months of symptom. Indications for fusion include neural arch defect, segmental instability with movement of more than 4.5 mm, revision surgery where functional gains are anticipated, infection, tumor, deformity and after a third disc herniation. In addition, ODG states, there is a lack of support for fusion for mechanical low back pain for subjects with failure to participate effectively in active rehab pre-op, total disability over 6 months, active psych diagnosis, and narcotic dependence. In this particular patient there is lack of medical necessity for lumbar fusion as there is no evidence of segmental instability greater than 4.5 mm or psychiatric clearance from the exam note of 5/21/14 to warrant fusion. Therefore the determination is non-certification for lumbar fusion.

#### **(Associate service) Inpatient hospitalization: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines: Lumbar spine; Hospital LOS

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Low back, Length of stay

**Decision rationale:** The ACOEM Guidelines Chapter 12 Low Back Complaints page 307 state that lumbar fusion, "Except for cases of trauma-related spinal fracture or dislocation, fusion of the spine is not usually considered during the first three months of symptoms. Patients with increased spinal instability (not work-related) after surgical decompression at the level of degenerative spondylolisthesis may be candidates for fusion." According to the ODG, Low back,

Fusion (spinal) should be considered for 6 months of symptom. Indications for fusion include neural arch defect, segmental instability with movement of more than 4.5 mm, revision surgery where functional gains are anticipated, infection, tumor, deformity and after a third disc herniation. In addition, ODG states, there is a lack of support for fusion for mechanical low back pain for subjects with failure to participate effectively in active rehab pre-op, total disability over 6 months, active psych diagnosis, and narcotic dependence. In this particular patient there is lack of medical necessity for lumbar fusion as there is no evidence of segmental instability greater than 4.5 mm or psychiatric clearance to warrant fusion. Therefore the determination is non-certification for lumbar fusion.

**(Associate services) Medical clearance: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACC/AHA 2007 Guidelines

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Low back, Preoperative testing

**Decision rationale:** As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.

**Assistant Surgeon: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation American Association of Orthopaedic Surgeon, Position Statement Reimbursement of the First Assistant at Surgery in Orthopaedics: Role of the First Assistant

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation <http://www.aaos.org/about/papers/position/1120.asp>

**Decision rationale:** As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.

**(Associate services) Pre-admit physical therapy evaluation: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation (ACOEM) Occupational Medical Practice Guidelines, 2nd Edition, Chapter 7, page 127

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical medicine, page 98-99.

**Decision rationale:** As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.