

<b>Case Number:</b>	CM15-0124197		
<b>Date Assigned:</b>	07/15/2015	<b>Date of Injury:</b>	04/23/2013
<b>Decision Date:</b>	09/10/2015	<b>UR Denial Date:</b>	06/09/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/29/2015

### 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:

The injured worker is a 33 year old male, who sustained an industrial injury on 4/23/2013. He reported low back and right leg pain after pushing/pulling activity. Diagnoses include lumbosacral facet arthropathy, radiculopathy, chronic intractable pain and status post microdiscectomy and laminotomy on 12/4/13. Treatments to date include chiropractic therapy, epidural injections, medication therapy. Currently, he complained of low back pain with radiation to lower extremity. On 5/28/15, the physical examination documented palpable tenderness to lumbar region and decreased sensation in right lower extremity. There was a positive right side straight leg raise test. The plan of care included lumbar fusion of L4-5 and L5-S1 levels with cage and instrumentation. The appeal request was to authorize a 3-1 commode, surgical assistant, co-vascular surgeon, cold therapy unit, front wheeled walker, and L4-S1 anterior lumbar interbody fusion with cage and instrumentation. MRI lumbar spine from May 8, 2014 demonstrates disc degeneration with annular bulging at L4 beyond the endplate margin eccentric to the right. The neural foraminal area was noted be patent bilaterally at L4-L5. Moderate facet arthropathy is noted bilaterally. At L5-S1 there is mild disc desiccation with annular bulging 3 mm beyond the endplate margin. No significant central canal or foraminal stenosis. Request is made for a 2 level anterior lumbar interbody fusion L4-S1.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Anterior lumbar interbody fusion with cage and instrumentation and Posterior spinal instrumentation and fusion at L4-S1: 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): 307. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) 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, severe stenosis from the exam note of 5/28/15 or the MRI of 5/8/14 to warrant fusion. Therefore the determination is not medically necessary for lumbar fusion.

**Associated surgical service: Assistant surgeon: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 307.

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

**Associated surgical service: Co-vascular surgeon: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 307.

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

**Pre-op medical clearance:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 307.

**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.

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

**Associated surgical service: LSO brace:** 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): 301.

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

**Associated surgical service: Orthofix bone growth stimulator:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 307.

**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 stimulator.

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

**Associated surgical service: Front wheel walker:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 307.

**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.

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

**Associated surgical service: 3-1 Commode:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 307.

**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, DME toilet items.

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

**Associated surgical service: Cold therapy unit:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 307; CharFormat

**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, continuous flow cryotherapy.

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

**Associated surgical service: Pneumatic intermittent compression device:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 2 General Approach to Initial Assessment and Documentation, Chapter 12 Low Back Complaints Page(s): 307.

**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, venous thrombosis.

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

**Associated surgical service: Hospital stay x 3 days:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 307.

**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.

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

**Post-op physical therapy 3 x 6 to the lumbar spine:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 307.

**MAXIMUS guideline:** Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 25-26.

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

**Pre-op chest x-ray:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 307.

**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.

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