

<b>Case Number:</b>	CM15-0168651		
<b>Date Assigned:</b>	09/09/2015	<b>Date of Injury:</b>	01/08/2001
<b>Decision Date:</b>	11/02/2015	<b>UR Denial Date:</b>	08/22/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/27/2015

### 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 40 year old male who sustained an industrial injury on 01-08-2001. Mechanism of injury occurred when he was involved in a bending and twisting industrial injury in his job as a correctional officer. Diagnoses include chronic low back pain, chronic pain syndrome, lumbar degenerative disc disease, and lumbar radiculitis secondary to L4-L5 disc protrusion with foraminal and subarticular stenosis and myalgia. Physician progress notes dated from 05-07-2015 to 08-10-2015 documents the injured worker complains of equally severe low back pain and right leg pain, he has intermittent tingling of the right dorsal foot. He has decreased range of motion. He has tenderness of the right sciatic notch. He has increased bilateral heel pain with walking. Sensation is decreased at the right L4 and L5 dermatome. His pain was reproduced with active lumbar extension between 0 and 120 degrees. The sciatic nerve stretch test was positive on the right and negative on the left. Treatment to date has included diagnostic studies, medications, psychiatric evaluation, physical therapy, and bilateral S1 transforaminal epidural steroid injections. A Magnetic Resonance Imaging of the lumbar spine done on 04-24-2015 revealed a broad based disc bulge at L4-5 with maximum traverse diameter of 5.7 cm and no focal disc protrusion. There is mild narrowing of the central canal and mild right and left neuroforaminal narrowing. There is no significant neural impingement. He is currently cleared for modified duty but he is not working. The original utilization Review done on 08-22-2015 non-certifies the request for anterior lumbar L4-L5 discectomy and interbody fusion using a PEEK spacer filled with bone morphogen. There is no evidence of recent reasonable and or comprehensive non-operative treatment protocol trial and failure submitted for this review. Dynamic extension-flexion films are not provided to corroborate instability. The

original utilization Review done on 08-22-2014 finds this request is non-applicable; associated surgical service: Raised toilet seat due to surgery is not medically necessary at this time. The original utilization Review done on 08-22-2015 finds this request is non-applicable; associated surgical service: Grabber due to surgery is not medically necessary at this time. The original utilization Review done on 08-22-2015 finds this request is non-applicable; associated surgical service: Facility Inpatient for 3 days due to surgery is not medically necessary at this time. The original utilization Review done on 08-22-2015 finds this request is non-applicable-associated the request for an assistant surgeon due to surgery is not medically necessary at this time. The original utilization Review done on 08-22-2015 finds this request is non-applicable-associated surgical service: Walker with front wheel due to surgery is not medically necessary at this time.

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

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

**Anterior lumbar L4-L5 discectomy and interbody fusion using a PEEK spacer filled with bone morphogen:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Low Back Complaints 2004.

**MAXIMUS guideline:** Decision based on MTUS Low Back Complaints 2004, Section(s): Surgical Considerations. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low back, Lumbar 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 8/10/15 to warrant fusion. Therefore, the determination is not medically necessary for lumbar fusion.

**Associated surgical service: Facility Inpatient for 3 days:** Upheld

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

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

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

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Treatment Integrated Treatment/ Disability Duration Guidelines Low Back Chapter.

**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.

**Associated surgical service: Walker with front wheels: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Treatment Integrated Treatment/ Disability Duration Guidelines Knee and Leg Chapter.

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

**Associated surgical service: Raised toilet seat: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Treatment Integrated Treatment/ Disability Duration Guidelines, Knee and Leg Chapter.

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

**Associated surgical service: Grabber: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Treatment Integrated Treatment/ Disability Duration Guidelines, Knee and Leg Chapter.

**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.

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