

<b>Case Number:</b>	CM15-0024981		
<b>Date Assigned:</b>	02/17/2015	<b>Date of Injury:</b>	04/11/2013
<b>Decision Date:</b>	04/01/2015	<b>UR Denial Date:</b>	02/02/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/10/2015

### 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: 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:

The injured worker is a 38-year-old female who sustained an industrial injury on 4/11/13. Past surgical history was positive for L5/S1 discectomy on 4/4/14. Records documented medical examiner findings on 9/5/14 of positive Waddell's signs, subjective complaints out of proportion to objective findings, and poor effort on muscle testing. The 10/30/14 lumbar spine MRI impression documented posterior disc bulge at L3/4 through L5/S1. At L5/S1, there was a 5 to 6 mm disc protrusion with mild to moderate L5/S1 central canal narrowing. The 11/7/14 electrodiagnostic study impression documented no evidence of lumbosacral radiculopathy, plexopathy or peripheral nerve entrapment. The 12/9/14 treating physician report was positive for depressed mood and affect. There was cogwheel breakaway weakness noted with symmetrical 5/5 lower extremity muscle strength. The 1/22/15 treating physician report cited constant grade 6-7/10 back pain with pulsating pain in the left leg aggravated by walking. Physical exam revealed lumbar tenderness and decreased range of motion (ROM) with positive Gower's sign. Straight leg raise test was negative. Neurologic exam demonstrated 5/5 motor testing, 1+ and symmetrical patellar and Achilles reflexes, normal sensation, and negative clonus. The diagnosis was severe discogenic low back pain emanating from L5/S1. The injured worker had failed all reasonable forms of conservative treatment including physical therapy, home exercise program, activity modification, medication, and a discectomy. Her pain was mechanical in nature, and she was an appropriate candidate for an L5/S1 fusion. On 2/2/15, utilization review non-certified a request for L5-S1 anterior instrumentation, L5-S1 lumbar interbody fusion, L5-S1 intervertebral device with bone morphogenetic protein, medical

clearance, one day inpatient stay, assistant surgeon and DME: corset. The Medical Treatment Utilization Schedule (MTUS) American College of Occupational and Environmental Medicine (ACOEM) and Official Disability Guidelines (ODG) were utilized in the determination. Application for independent medical review (IMR) is dated 2/9/15. The rationale for non-certification was based on no evidence lumbar instability, no psychological clearance, no neurologic deficits, and no guideline support for bone morphogenetic proteins.

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

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

#### **L5-S1 Anterior Instrumentation: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 307,310. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Lumbar & Thoracic Chapter.

**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 i;½ Lumbar & Thoracic, Fusion (spinal).

**Decision rationale:** The California MTUS guidelines state there is no good evidence that spinal fusion alone was effective for treating any type of acute low back problem, in the absence of spinal fracture, dislocation, or spondylolisthesis if there was instability and motion in the segment operated on. The guidelines recommend that clinicians consider referral for psychological screening to improve surgical outcomes. The Official Disability Guidelines (ODG) state that spinal fusion is not recommended for patients who have less than six months of failed recommended conservative care unless there is objectively demonstrated severe structural instability and/or acute or progressive neurologic dysfunction. Pre-operative clinical surgical indications require completion of all physical therapy and manual therapy interventions, x-rays demonstrating spinal instability, spine pathology limited to 2 levels, and psychosocial screening with confounding issues addressed. Guideline criteria have not been met. There is no radiographic evidence of spinal segmental instability. There is no clinical exam evidence of a significant neurologic deficit. There is no imaging evidence of nerve root compression. Potential psychological issues are noted with no evidence of a psychosocial evaluation. Detailed evidence of a recent, reasonable and/or comprehensive non-operative treatment protocol trial and failure has not been submitted. Therefore, this request is not medically necessary.

#### **L5-S1 lumbar interbody fusion: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 307,310. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Lumbar & Thoracic Chapter.

**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 i;½ Lumbar & Thoracic, Fusion (spinal).

**Decision rationale:** The California MTUS guidelines state there is no good evidence that spinal fusion alone was effective for treating any type of acute low back problem, in the absence of spinal fracture, dislocation, or spondylolisthesis if there was instability and motion in the segment operated on. The guidelines recommend that clinicians consider referral for psychological screening to improve surgical outcomes. The Official Disability Guidelines (ODG) state that spinal fusion is not recommended for patients who have less than six months of failed recommended conservative care unless there is objectively demonstrated severe structural instability and/or acute or progressive neurologic dysfunction. Pre-operative clinical surgical indications require completion of all physical therapy and manual therapy interventions, x-rays demonstrating spinal instability, spine pathology limited to 2 levels, and psychosocial screening with confounding issues addressed. Guideline criteria have not been met. There is no radiographic evidence of spinal segmental instability. There is no clinical exam evidence of a neurologic deficit. There is no imaging evidence of nerve root compression. Potential psychological issues are noted with no evidence of a psychosocial evaluation. Detailed evidence of a recent, reasonable and/or comprehensive non-operative treatment protocol trial and failure has not been submitted. Therefore, this request is not medically necessary.

**L5-S1 intervertebral device with bone morphogenic protein:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 310. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Lumbar & Thoracic Chapter.

**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 & 1/2 Lumbar & Thoracic: Bone-morphogenetic protein (BMP).

**Decision rationale:** The California MTUS guidelines do not address the use of bone morphogenetic protein (BMP). The Official Disability Guidelines state that BMP is not recommended. There is a lack of clear evidence of improved outcomes with BMP, and there is inadequate evidence of safety and efficacy to support routine use. Given the absence of guideline support and lacking established medical necessity for the associated fusion, this request is not medically necessary.

**Medical Clearance:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines.

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

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

**One day inpatient stay:** 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) Lumbar & Thoracic Chapter; Hospital Length of Stay (LOS).

**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  $\frac{1}{2}$  Lumbar & Thoracic: Hospital length of stay (LOS).

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

**Assistant surgeon:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation The Milliman Care Guidelines, 12th edition.

**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  $\frac{1}{2}$  Lumbar & Thoracic: Surgical assistant.

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

**DME: Corset:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 301. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Lumbar & Thoracic Chapter; Back Brack, Post Operative (fusion).

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

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