

Case Number:	CM13-0011656		
Date Assigned:	12/18/2013	Date of Injury:	09/15/2012
Decision Date:	03/06/2014	UR Denial Date:	08/02/2013
Priority:	Standard	Application Received:	08/15/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Orthopedic Surgery and is licensed to practice in Texas. 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 physician 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 patient is a 43-year-old male who reported an injury on 09/15/2012. The patient is currently diagnosed with disc herniation at L5-S1 with nerve root impingement, right L5-S1 facet cyst, severe L5-S1 pain, T11-12 severe painful disc level, grade 1 retrolisthesis at L5-S1, and onset of partial bladder incontinence. The patient was seen by [REDACTED] on 12/02/2013. The patient reported worsening lower back pain with radiation to bilateral lower extremities. The patient also reported mid back pain with radiation to the upper extremities causing numbness and weakness. Physical examination revealed tenderness to palpation over the lumbar spine at L4-5 and L5-S1, palpable muscle spasm, limited range of motion, decreased strength, and diminished sensation in the right L5-S1 distribution. The patient also demonstrated positive straight leg raising. Treatment recommendations included authorization for an L5-S1 anterior and posterior fusion followed by postoperative physical therapy.

IMR ISSUES, DECISIONS AND RATIONALES

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

L5-S1 anterior and posterior fusion: 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).

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 Chapter, Decompression, Fusion (spinal).

Decision rationale: The Physician Reviewer's decision rationale: California MTUS/ACOEM Practice Guidelines state surgical consultation is indicated for patients who have severe and disabling lower extremity symptoms, activity limitation for more than 1 month, extreme progression of symptoms, clear clinical, imaging and electrophysiological evidence of a lesion that has been shown to benefit from surgical repair, and a failure of conservative treatment. Patients with increased spinal instability after surgical decompression at the level of degenerative spondylolisthesis may be candidates for a fusion. As per the documentation submitted, the patient does demonstrate diminished sensation in the L5-S1 distribution as well as decreased range of motion, decreased strength and positive straight leg raising. However, the patient underwent electrodiagnostic studies on 01/23/2013, which revealed no evidence of lumbosacral radiculopathy. Flexion and Extension View X-rays were not submitted for this review. Although it is noted that the patient's MRI indicated spondylolisthesis at L5-S1 (viewed by the requesting provider), and an updated EMG study indicated radiculopathy at L5-S1 (by [REDACTED]), these independent studies were not provided for this review. Additionally, there has not been any psychological evaluation prior to the requested surgical intervention. Based on the clinical information received, the request is non-certified.

T11-12 anterior fusion through Thoracotomy and posterior stabilization: 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).

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 Chapter, Decompression, Fusion (spinal).

Decision rationale: The Physician Reviewer's decision rationale: California MTUS/ACOEM Practice Guidelines state surgical consultation is indicated for patients who have severe and disabling lower extremity symptoms, activity limitation for more than 1 month, extreme progression of symptoms, clear clinical, imaging and electrophysiological evidence of a lesion that has been shown to benefit from surgical repair, and a failure of conservative treatment. Patients with increased spinal instability after surgical decompression at the level of degenerative spondylolisthesis may be candidates for a fusion. As per the documentation submitted, the patient does demonstrate diminished sensation in the L5-S1 distribution as well as decreased range of motion, decreased strength and positive straight leg raising. However, the patient underwent electrodiagnostic studies on 01/23/2013, which revealed no evidence of lumbosacral radiculopathy. Flexion and Extension View X-rays were not submitted for this review. Although it is stated that the patient demonstrated positive T11-12 extrusion with hyperreflexia in the lower extremity on MRI (viewed by the requesting provider), the independent studies were not provided for this review. Additionally, there has not been any psychological evaluation prior to the requested surgical intervention. Based on the clinical information received, the request is non-certified.

Pre-op clearance: 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).

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 Chapter, Preoperative Testing, General.

Decision rationale: The Physician Reviewer's decision rationale: Official Disability Guidelines state preoperative testing including chest radiography, laboratory testing, and echocardiography is often performed before surgical procedures. The decision to order preoperative tests should be guided by the patient's clinical history, comorbidities, and physical examination findings. The patient has no past medical history, as documented on 12/02/2013 by [REDACTED]. Therefore, the medical necessity of pre-operative clearance has not been established. As the patient's surgical procedures have not been authorized, the current request for preoperative clearance is not medically necessary. As such, the request is non-certified.

Vascular and thoracic surgeon for stage One (1): 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).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 5 Cornerstones of Disability Prevention and Management Page(s): 89-92.

Decision rationale: The Physician Reviewer's decision rationale: California MTUS/ACOEM Practice Guidelines state referral may be appropriate if the practitioner is uncomfortable with the line of inquiry, with treating a particular cause of delayed recovery, or has difficulty obtaining information or an agreement to a treatment plan. As the patient's surgical procedure has not been authorized, the current request for a vascular and thoracic surgeon is not medically necessary. Therefore, the request is non-certified.

Assistance surgeon for stage two (2): 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).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 5 Cornerstones of Disability Prevention and Management Page(s): 89-92.

Decision rationale: The Physician Reviewer's decision rationale: California MTUS/ACOEM Practice Guidelines state referral may be appropriate if the practitioner is uncomfortable with the line of inquiry, with treating a particular cause of delayed recovery, or has difficulty obtaining information or an agreement to a treatment plan. As the patient's surgical procedure has not been

authorized, the current request for a vascular and thoracic surgeon is not medically necessary. Therefore, the request is non-certified.

Seven (7) days inpatient hospital 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).

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 Chapter, Hospital Length of Stay.

Decision rationale: The Physician Reviewer's decision rationale: Official Disability Guidelines state hospital length of stay following a lumbar fusion includes a median of 3 days. As the patient's surgical procedure has not been authorized, the current request cannot be determined as medically appropriate. Therefore, the request is non-certified.

LSO brace: 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).

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 Chapter, Back brace, post-operative (fusion).

Decision rationale: The Physician Reviewer's decision rationale: Official Disability Guidelines state a postoperative back brace following a fusion is currently under study, and given the lack of evidence supporting the use of these devices, a standard brace would be preferred over a custom postoperative brace. As the patient's surgical procedure has not been authorized, the current request cannot be determined as medically appropriate. Therefore, the request is non-certified.

Cold Therapy unit: 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).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck & Upper Back Chapter, Continuous-flow cryotherapy.

Decision rationale: The Physician Reviewer's decision rationale: Official Disability Guidelines state continuous flow cryotherapy is not recommended in the cervical spine. It is recommended as an option after shoulder surgery for postoperative use, generally up to 7 days. As there are no Guideline recommendations for the requested post-operative DME, the request is not medically

appropriate. As the patient's surgical procedure has not been authorized, the current request is non-certified.

Bone Growth Stimulator: 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).

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 Chapter, Bone Growth Stimulator.

Decision rationale: The Physician Reviewer's decision rationale: Official Disability Guidelines state either invasive or noninvasive methods of electrical bone growth stimulation may be considered medically necessary as an adjunct to spinal fusion surgery for patients with risk factors such as 1 or more previous failed spinal fusions, grade 3 or worse spondylolisthesis, fusion to be performed at more than 1 level, a current smoking habit, diabetes, renal disease, alcoholism, or significant osteoporosis. As the patient's surgical procedure has not been authorized, the current request cannot be determined as medically appropriate. Therefore, the request is non-certified.