

Case Number:	CM13-0047186		
Date Assigned:	01/15/2014	Date of Injury:	08/06/2003
Decision Date:	05/02/2014	UR Denial Date:	10/24/2013
Priority:	Standard	Application Received:	11/05/2013

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. The expert reviewer is Board Certified in Orthopedic Surgery, and is licensed to practice in California. 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/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 records indicate the claimant is a 48 year old female with a reported injury date of May 20, 2004. The claimant reportedly has a history of chronic low back pain and underwent a previous L3-4 partial laminectomy with discectomy and foraminotomy on July 12, 2007. The records suggest she has multilevel degenerative disc disease with desiccation and bulging. More specifically the claimant is reported to have protrusions at L3-4, L4-5 and L5-S1 with chronic lumbar radiculopathy. She has been referred for psychological treatment and weight loss as the claimant is noted to have morbid obesity. The claimant, according to the records provided, is to complete a weight loss program including surgery before plans for lumbar spine surgery and L4 through S1 fusion has been requested.

IMR ISSUES, DECISIONS AND RATIONALES

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

L4-5, L5-S1 POSTERIOR LUMBAR INTERBODY FUSION, AND 2-DAY INPATIENT STAY: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Upper Neck and Back; and National Guideline Clearinghouse.

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),

Treatment in Worker's Comp, 18th Edition, low back procedure - Fusion (spinal) for average hospital LOS after criteria are met, see Hospital length of stay (LOS).

Decision rationale: The requested lumbar fusion cannot be recommended as medically necessary for a number of reasons. The claimant has been noted to have a diagnosis of radiculopathy; there is no consistent objective evidence on examination. There are no postoperative imaging studies to evaluate for neurocompressive pathology; there are no flexion/extension views noted to document structural instability for the claimant. The claimant has not been fully treated for her obesity as was planned before any spinal surgery would be undertaken. It is unclear why a fusion has been requested as the ACOEM Guidelines do not generally advocate fusion in the absence of structural instability, spondylolisthesis or severe loss of expected disc height. The guidelines suggest there is no good evidence from controlled trials that spine fusion is effective for treating back pain in the absence of fracture, dislocation or spondylolisthesis with instability. For all of these reasons the records do not support lumbar spine fusion or indicate the request has met the CA MTUS Guidelines. The request for a two day inpatient stay would not be medically necessary as the surgery is not recommended as medically necessary.

PROSTIM UNIT WITH SUPPLIES: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM. Decision based on Non-MTUS Citation Official Disability Guidelines ODG, Upper Neck and Back; and National Guideline Clearinghouse.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation (ICS) Page(s): 118, 120.

Decision rationale: The request for the lumbar fusion is not recommended as medically necessary. Therefore, the request for a Pro Stim unit is not indicated.

MOTORIZED HOT/COLD THERAPY UNIT: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM. Decision based on Non-MTUS Citation Official Disability Guidelines ODG, Upper Neck and Back; and National Guideline Clearinghouse.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Treatment In Worker's Comp, 18th Edition, Cryotherapy: See Cold/Head Packs.

Decision rationale: The proposed lumbar fusion is not recommended as medically necessary. Therefore, the motorized heat and cold treatment to the lumbar spine is not indicated.

BONE GROWTH STIMULATOR: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM. Decision based on Non-MTUS Citation Official Disability Guidelines ODG, Upper Neck and Back; and National Guideline Clearinghouse.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Treatment In Worker's Comp, 18th Edition, Low Back Procedure - Bone Growth Stimulators (Bgs).

Decision rationale: The proposed lumbar fusion is not recommended as medically necessary. Therefore, the request for a bone growth stimulator is not indicated.

POSTOPERATIVE EVALUATION BY AN RN: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM. Decision based on Non-MTUS Citation Official Disability Guidelines ODG, Upper Neck and Back; and National Guideline Clearinghouse.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 51.

Decision rationale: The proposed lumbar fusion cannot be recommended as medically necessary. Therefore, the need for home health nursing assessment is not necessary.

HOME HEALTH CARE POSTOPERATIVELY: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM. Decision based on Non-MTUS Citation Official Disability Guidelines ODG, Upper Neck and Back; and National Guideline Clearinghouse.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 51.

Decision rationale: The proposed lumbar fusion is not recommended as medically necessary. Therefore, the request for home health nursing assistance would not be necessary.

12 POSTOPERATIVE PHYSICAL THERAPY SESSIONS: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM. Decision based on Non-MTUS Citation Official Disability Guidelines ODG, Upper Neck and Back; and National Guideline Clearinghouse.

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment Guidelines.

Decision rationale: The proposed lumbar fusion is not recommended as medically necessary. Therefore, the request for postoperative physical therapy would not be necessary.

ZOFRAN: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM. Decision based on Non-MTUS Citation Official Disability Guidelines ODG, Upper Neck and Back; and National Guideline Clearinghouse.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Treatment In Worker's Comp, 18th Edition, Pain Procedure - Antiemetics (For Opioid Nausea).

Decision rationale: The proposed lumbar fusion is not recommended as medically necessary. Therefore, the request for Zofran would not be necessary.

DURACEF: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM. Decision based on Non-MTUS Citation Official Disability Guidelines ODG, Upper Neck and Back; and National Guideline Clearinghouse.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Treatment In Worker's Comp, 18th Edition, Infectious Process - Cefadroxil (Duricef®).

Decision rationale: The proposed lumbar fusion cannot be recommended as medically necessary. Therefore, the request for a perioperative antibiotic is not necessary.

NORCO: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM. Decision based on Non-MTUS Citation Official Disability Guidelines ODG, Upper Neck and Back; and National Guideline Clearinghouse.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 76-80.

Decision rationale: The request for a lumbar fusion is not recommended as medically necessary. Therefore, the request for Norco in the postoperative setting is not medically necessary.