

<b>Case Number:</b>	CM13-0049427		
<b>Date Assigned:</b>	12/27/2013	<b>Date of Injury:</b>	03/27/2009
<b>Decision Date:</b>	09/29/2014	<b>UR Denial Date:</b>	10/31/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/07/2013

### 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, has a subspecialty in Spine 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 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 claimant was injured on 3/27/2009 having fallen out of a chair while sleeping and has complaints of back pain with bilateral leg pain with numbness and tingling, along with neck pain, right shoulder and arm pain with numbness and tingling. Treating physician note on 9/20/13 reveal the patient uses narcotic pain medications along with Lyrica, Zanaflex, and Xanax for symptom control. The exam on this date shows the patient to have forward stooped posture and requires the use of a walker. There is visible kyphosis and scoliosis and tenderness to palpation of the thoracic and lumbar spines. Ranges of motion cannot be performed due to pain. Straight leg test is positive on the left and lower extremity muscle strengths are normal. Imaging studies referred to on this note include magnetic resonancy imaging and CT scans of the lumbar spine revealing 26-28 degree scoliosis of the lumbar spine with severe L3-4, L4-5 and L5-S1 disc space narrowing and multiple level foraminal stenosis. There are pars defects bilaterally at L5 and spondylolisthesis of L4-5. Magnetic resonance imaging of the cervical spine reveals congenital C5-6 fusion with degenerative changes and mild to moderate stenosis at multiple levels. Diagnoses include congenital cervical fusion C5-6, anterolisthesis C4 on C5, lumbar degenerative disc disease, spondylolisthesis and spinal stenosis. The doctor states her scoliosis is progressing. On 10/18/13 the treating doctor note indicates the patient has had extensive physical therapy which has only increased the pain. The exam on this date reveals restricted spine range of motion with motor weakness of hip flexion bilaterally, absent patellar reflexes and a positive straight leg raise test. Thoracic magnetic resonance imaging reveals a 16 degree scoliosis with degenerative disc disease. The doctor recommends L3-S1 or L4-S1 anterior lumbar fusion with T6\_S1 fusion with osteotomies. Psychological evaluation on 11/20/13 indicates no psychological contraindications to the surgery. Treating physician note 11/27/13 reveals continued pain complaints, with gradually worsening motor strength in the legs and

continued positive straight leg test. The doctor continues to suggest the spinal fusion, with 7 day length of hospital stay.

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

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

#### **L3-S1 OR L4-S1 ALIF: Overturned**

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305.

**Decision rationale:** The claimant has a degenerative scoliosis with imaging studies consistent with severe degenerative disc disease and instability in the form of spondylolisthesis. Additionally the claimant has moderate to severe multilevel foraminal stenosis resulting in bilateral radiculopathies involving multiple nerve roots. There has been adequate conservative care without improvement in symptoms and the claimants leg symptoms are worsening. As such, medical necessity has been established.

#### **T6-S1 PSIF WITH OSTEOTOMIES AT L1-3: Overturned**

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305.

**Decision rationale:** The claimant has a degenerative scoliosis with imaging studies consistent with severe degenerative disc disease and instability in the form of spondylolisthesis. Additionally the claimant has moderate to severe multilevel foraminal stenosis resulting in bilateral radiculopathies involving multiple nerve roots. There has been adequate conservative care without improvement in symptoms and the claimants leg symptoms are worsening. As such, medical necessity has been established.

#### **INPATIENT HOSPITAL LENGTH OF STAY 10-14 DAYS: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Inpatient length of stay

**Decision rationale:** MTUS does not address length of stay for thoracic spinal fusion. ODG indicates a 5 day length of stay is appropriate for posterior spinal fusion. Medical necessity has not been established to exceed guideline recommendations.

**TWO WEEKS OF ACUTE POST OP REHAB ADMISSION:** Overturned

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG) INPATIENT REHAB

**Decision rationale:** MTUS does not address post surgical inpatient rehab for spinal fusion. ODG allows 6-12 days of inpatient rehab following a 3 day hospital stay for major surgery including spine surgery when the physician certifies the need for significant functional limitations. The claimant would expect to need assistance with activities of daily living as outlined in the guidelines.

**HOME HEALTH CARE 12/HRS A DAY FOR 7 DAYS:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

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

**Decision rationale:** Home health services are recommended only for otherwise recommended medical treatment for patients who are homebound, on a part-time or "intermittent" basis, generally up to no more than 35 hours per week.

**PRE-OP MEDICAL CLEARANCE AND CHEST X-RAY:** Overturned

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-307.

**Decision rationale:** Preoperative assessment of the patient prior to a multi-level spinal fusion such as this which carries with it a high risk of blood loss and cardiopulmonary complications is appropriate. Medical necessity has been established.

**TLSO BRACE:** Overturned

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG) LUMBOSACRAL ORTHOTICS

**Decision rationale:** ODG indicates postoperative bracing may be indicated in multilevel fusions such as the procedure in this case. A TLSO is used to support the thoracic, lumbar and sacral levels included in this surgical procedure. Medical necessity has been established.

**PNEUMATIC INTERMITTENT COMPRESSION DEVICE:** Overturned

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: North American Spine Society Evidence-Based Clinical Guidelines for Multidisciplinary Spine Care, pages 17-19.

**Decision rationale:** Pneumatic compression devices are appropriate for prophylaxis of deep vein thrombosis in major spine surgery with little risk associated with their use. Medical necessity has been established.

**BONE GROWTH STIMULATOR DUE TO MULTILEVEL FUSION:** Overturned

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG) MUSCLE STIMULATOR

**Decision rationale:** Bone Growth Stimulators are considered appropriate for fusion at more than one level such as this surgical procedure. Medical necessity has been established.

**FRONT WHEELED WALKER:** Overturned

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**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

**Decision rationale:** Guidelines don't specifically address the use of a walker for lumbar spinal fusion but will need an assistive device for ambulation postoperatively.

**3:1 COMMODE:** Overturned

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG) KNEE, DURABLE MEDICAL EQUIPMENT

**Decision rationale:** Guidelines do not address this, however the commode will allow safer toileting following major spine surgery.

**CO-SURGEON- [REDACTED]:** Overturned

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**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, SURGICAL ASSISTANT

**Decision rationale:** A co-surgeon trained for exposure to the anterior aspect of the lumbar spine is appropriate for the anterior lumbar interbody fusion requested and approved.

**VASCULAR SURGEON:** Overturned

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**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, SURGICAL ASSISTANT

**Decision rationale:** As indicated in the co-surgeon section, a surgeon trained in the anterior exposure of the lumbar spine and the great vessels is appropriate for the anterior lumbar interbody fusion.

**ASSISTANT SURGEON [REDACTED], PA:** Overturned

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**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, Surgical Assistant

**Decision rationale:** An assistant surgeon is appropriate for the posterior fusion surgeries when the co-surgeon is no longer involved in the case.

**XANAX 1 MG, #90:** Overturned

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines BENZODIAZEPINES Page(s): 24.

**Decision rationale:** Benzodiazepines are not recommended for long-term use because long-term efficacy is unproven and there is a risk of dependence. Most guidelines limit use to 4 weeks. Their range of action includes sedative/hypnotic, anxiolytic, anticonvulsant, and muscle relaxant. Chronic benzodiazepines are the treatment of choice in very few conditions. Tolerance to hypnotic effects develops rapidly. Tolerance to anxiolytic effects occurs within months and long-term use may actually increase anxiety. A more appropriate treatment for anxiety disorder is an antidepressant. Tolerance to anticonvulsant and muscle relaxant effects occurs within weeks. The 90 tablet prescription would appear to exceed these parameters.

**Omeprazole dr 20mg #60:** Overturned

No guidelines were cited by the Claims Administrator.

The Expert Reviewer based his/her decision on the MTUS Chronic Pain Medical Treatment Guidelines, NSAIDS, GI symptoms and cardiovascular risk, page(s) 68.

**Decision rationale:** MTUS allows for the use of omeprazole for patients with risk factors for gastrointestinal events. None of the risk factors are described for the claimant.

**Hydromorphone 4mg #180:** Overturned

No guidelines were cited by the Claims Administrator.

The Expert Reviewer based his/her decision on the MTUS Chronic Pain Medical Treatment Guidelines, Opioids, page(s) 74-93.

**Decision rationale:** MTUS allows for the use of narcotics for moderate to severe pain as would be expected in this case.