

<b>Case Number:</b>	CM14-0001433		
<b>Date Assigned:</b>	01/22/2014	<b>Date of Injury:</b>	10/02/2012
<b>Decision Date:</b>	06/10/2014	<b>UR Denial Date:</b>	12/24/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/03/2014

### 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 California, Texas, Tennessee, and Oklahoma. 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 45 year old male who reported an injury to his low back on 10/02/12 while performing duties as a field worker. The MRI of the lumbar spine dated 04/24/13 revealed 4-5mm broad based posterior and bilateral intraforaminal disc protrusions at L1-2, L2-3, L3-4, L4-5, and L5-S1. These disc protrusions were identified as indenting and impinging on the anterior thecal sac with no significant spinal canal, lateral recess, or neuroforaminal stenosis. The MRI of the lumbar spine dated 12/13/12 revealed a 5mm disc protrusion at T12-L1 impinging upon the conus. The clinical note dated 05/21/13 indicates the patient complaining of low back pain. The note indicates the patient stating the initial injury occurred when he was standing on the side of a trailer when he slipped off the edge and fell backwards. The patient reported worsening low back pain over the following 2-3 days. The note indicates the patient having undergone physical therapy for an undetermined period of time. The patient stated that physical therapy provided no benefit. Pain medications were prescribed in order to control the lumbar spine pain. The patient also underwent an epidural steroid injection in March of 2013 with no significant benefit. The patient reported ongoing constipation and nausea. The patient rated the pain in the low back as 10/10. The patient also reported numbness and tingling in the lower extremities. Radiating pain was also identified in both lower extremities. The patient also had complaints of weakness in the lower extremities. Upon exam, the patient was able to demonstrate decreased range of motion to include flexion, extension, and bilateral lateral bending. 3/5 strength was identified at the left EHL and 4/5 strength was identified at the left iliopsoas. The note indicates the patient utilizing a brace at that time. The clinical note dated 07/29/13 indicates the patient continuing with complaints of low back pain. The patient was recommended for a spinal surgery at T12-L1 as well as associated preoperative and postoperative treatments. The patient was also recommended for an L5-S1 decompression. The clinical note dated 10/26/13 indicates the

patient continuing with complaints of low back pain with associated range of motion deficits. The patient was identified as having a positive straight leg raise bilaterally. Hyperreflexia was identified in both lower extremities at the patella and Achilles regions. Strength deficits continued. The psychosocial evaluation completed on 11/20/13 indicates the patient presenting with a depressed affect. Testing revealed significant depression and anxious symptoms. The patient was recommended for individual psychotherapy once a week for 12 weeks to address the depressive and anxiety symptoms.

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

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

#### **SPINAL SURGERY OF T-12-L1 DECOMPRESSION WITH STABILIZATION (FUSION) WITH L5-S1 DECOMPRESSION: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 308-310. Decision based on Non-MTUS Citation ODG LOW BACK (UPDATED 12/4/13), DISCECTOMY/LAMINECTOMY AND SPINAL FUSION

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-306.

**Decision rationale:** The request for a T12-L1 decompression and stabilization with an L5-S1 decompression is non-certified. The documentation indicates the patient complaining of low back pain with radiating pain into the lower extremities. A decompression and fusion would be indicated provided the patient meets specific criteria to include imaging studies confirming the patient's neurocompressive findings. There is an MRI from 2012 indicating significant findings at the T12-L1 level. However, no information was submitted regarding the patient's significant findings at the L5-S1 level to include spinal canal, lateral recess, or neuroforaminal stenosis. Given that no information was submitted on the imaging studies confirming the patient's significant pathology at the L5-S1 level, this request is not indicated as medically necessary and appropriate.

#### **THERMO COOL UNIT WITH COMPRESSION X 7 DAY RENTAL: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 298-301. Decision based on Non-MTUS Citation ODG LOW BACK (UPDATED 12/4/13), COLD/HEAT PACKS; ODG KNEE AND LEG (UPDATED 11/29/13), COMPRESSION GARMENTS.

**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.

**Decision rationale:** Given the non-certification of the requested surgery, the additional request for a thermal cool unit with compression x 7 day rental is rendered non-certified.

**PRE-OP EVALUATION AND SURGICAL CLEARANCE:** 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) LOW BACK CHAPTER.

**Decision rationale:** Given the non-certification of the requested surgery, the additional request for a pre-op evaluation and surgical clearance is rendered non-certified.

**POST-OP PHYSICAL THERAPY 3X4:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 26.

**MAXIMUS guideline:** Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 16.

**Decision rationale:** Postoperative physical therapy 3 x a week x 4 weeks is non-certified. Given the non-certification of the requested surgery, the request for postoperative physical therapy is rendered non-certified.

**LUMBOSACRAL CORSET, TO BE FITTED PRE-OP AND WORN POST-OP:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 298-301. Decision based on Non-MTUS Citation ODG LOW BACK (UPDATED 12/4/13), LUMBAR SUPPORTS AND BACK BRACE, POST OPERATIVE 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 CHAPTER.

**Decision rationale:** The decision for a lumbosacral corset to be fitted pre-op and 1 post-op is non-certified. Given the non-certification of the requested surgery, the request for a lumbosacral corset is rendered non-certified.

**EXTERNAL BONE GROWTH STIMULATOR:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG LOW BACK (UPDATED 12/4/13), BONE GROWTH STIMULATORS (BGS).

**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.

**Decision rationale:** The request for an external bone growth stimulator is rendered non-certified. Given the non-certification of the surgery, the additional request for an external bone growth stimulator is rendered non-certified. Additionally, a bone growth stimulator is traditionally recommended for a multi-level fusion. The request involves only a 1 level fusion. Therefore, this request is non-certified.

**3-1 COMMODE:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG KNEE AND LEG (UPDATED 11/29/13), DURABLE MEDICAL EQUIPMENT (DME).

**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 CHAPTER.

**Decision rationale:** The decision of a 3-in-1 commode is non-certified. Given the non-certification of the surgery, this request is rendered non-certified.

**FRONT WHEEL WALKER:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG KNEE AND LEG (UPDATED 11/29/13), WALKING AIDS (CANES, CRUTCHES, BRACES, ORTHOSES, AND WALKERS).

**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.

**Decision rationale:** The request for a front wheel walker is rendered non-certified. Given the non-certification of the surgery, this request is rendered non-certified.

**IN HOME HEALTH NURSE FOR DAILY DRESSING CHANGES/WOUND CARE, 4 HOURS A DAY X 2 WEEKS:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG KNEE AND LEG (UPDATED 11/29/13), SKILLED NURSING FACILITY (SNF) CARE

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

**Decision rationale:** The decision for an in home health nurse for daily dressing changes and wound care 4 hours a day x 2 weeks is non-certified. Given the non-certification of the requested surgery, the additional request for a home health nurse is rendered non-certified.

**IN HOME CAREGIVER FOR DAILY HOUSEHOLD CHORES, PERSONAL HYGIENE, FOR A TOTAL OF 50 HOURS OVER A 2 WEEK PERIOD:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG LOW BACK, (UPDATED 12/4/13), HOME HEALTH SERVICES.

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

**Decision rationale:** The decision for an in home caregiver for daily household chores, personal hygiene for a total of 50 hours over a 2 week period is rendered non-certified. Given the non-certification of the requested surgery, this request is rendered non-certified. However, evidence based guidelines do not traditionally recommend the use of home caregivers as skilled nursing is typically recommended to address the patients post-operative needs.