MAXIMUS Federal Services

Case Number:	CM14-0003815		
Date Assigned:	02/03/2014	Date of Injury:	11/05/2011
Decision Date:	06/23/2014	UR Denial Date:	12/24/2013
Priority:	Standard	Application Received:	01/10/2014

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 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:

Medical records from 2012 to 2013 were reviewed. Patient complained of persistent low back pain, graded 8/10 in severity, aggravated with walking, standing, bending, and lifting. Patient likewise experienced pain at the right leg. Patient has diabetes and denies any use of tobacco. Physical examination of the lumbar spine revealed tenderness and restriction of motion by 50%. Motor strength was 5/5 on both lower extremities. Straight leg raise test on the right resulted to increased back and buttock pain; on the left, only back pain was produced. Gait was normal without use of assisted devices. Sensation was diminished at right L5 to S1 dermatomes. An MRI of the lumbar spine, dated December 18, 2012, showed severe disc desiccation at L5 to S1 level with endplate changes. There was moderate to severe bilateral foraminal stenoses and a large left annular tear. At the L4 to L5 level, there was a central disk protrusion measuring 4 mm; severe degenerative disc disease with disc space narrowing and severe bilateral foraminal stenoses. MRI of the lumbar spine, dated November 28, 2011, revealed multi-level degenerative changes most prominent at the L4 to L5 with left paracentral disc extrusion extending superiorly. Disc extrusion caused moderate left-sided neural foraminal stenoses at L4 to the S1 levels. Treatment to date has included physical therapy, and intake of medications such as cyclobenzaprine, diclofenac, pantoprazole, and metformin. Utilization review from December 24, 2013 denied the request for anterior lumbar decompression and interbody arthrodesis of L4 to L5 and L5 to S1 because there was no documentation that all conservative measures have been exhausted. Because of its noncertification, all of the associated requests were denied. These included 3 nights inpatient length of stay, assistant surgeon, pre-operative medical clearance to include lab work of ECG, chest x-ray, CBC, complete metabolic panel, PT/PTT INR, urinalysis; external bone stimulator, and lumbar support orthoses.

IMR ISSUES, DECISIONS AND RATIONALES

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

3 NIGHTS INPATIENT LENGTH OF STAY: Upheld

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 Section, Fusion (spinal)

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 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 Section, Fusion (spinal)

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

PURCHASE OF 1 EXTERNAL BONE GROWTH STIMULATOR: Upheld

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 Section, Fusion (spinal)

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

PRE-OPERATIVE LABS: CBC WITH DIFFERENTIAL, COMPLETE METABOLIC PANEL, PT/PTT - INR (PROTHROBIN TIME/PARTIAL PRO-THROMBIN TIME WITH INTERNATIONAL NORMALIZED RATIO) AND URINALYSIS (UA): 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 Section, Fusion (spinal)

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

PRE-OPERATIVE CLEARANCE TO INCLUDE EKG AND CHEST X-RAY,: Upheld

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 Section, Fusion (spinal)

Decision rationale: The dependent request of lumbar decompression and interbody arthrodesis has been deemed not medically necessary; therefore, all the associated services, such as, the request for PRE-OPERATIVE CLEARANCE TO INCLUDE EKG AND CHEST X-RAY is likewise not medically necessary.

PURCHASE OF 1 LUMBAR SUPPORT ORTHOSIS (LSO): Upheld

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 Section, Fusion (spinal)

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

ANTERIOR LUMBAR DECOMPRESSION AND INTERBODY ARTHRODESIS OF L405 AND L5-S1: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-307. Decision based on Non-MTUS Citation ODG - LOW BACK SECTION, FUSION (SPINAL)

Decision rationale: Pages 305 - 307 of Low Back Complaints ACOEM Guidelines state that lumbar surgical intervention is recommended for patients who have: severe lower leg symptoms

in the distribution consistent with abnormalities on imaging studies, preferably with accompanying objective signs of neural compromise; activity limitations for more than one month; clear imaging of a lesion; and failure of conservative treatment to resolve disabling radicular symptoms. In addition, ODG states that pre-operative lumbar surgical indications include all of physical medicine and manual therapy interventions are completed, and the patient should refrain from smoking for at least 6 weeks prior to surgery. In this case, patient has persistent low back pain radiating to the right lower extremity, associated with diminished sensation and positive provocative testing. This resulted to intolerance upon prolonged standing and walking. MRI of the lumbar spine, dated December 18, 2012, revealed disc protrusion of 4 mm with severe disc space narrowing and bilateral foraminal stenosis at L4 to L5 and L5 to S1 levels. There was documentation regarding lack of improvement from physical therapy. However, the total number of physical therapy sessions attended is unknown due to lack of documentation. Furthermore, all forms of conservative management have not been exhausted. It is unclear why the patient was not subjected to lumbar epidural steroid injections. Moreover, smoking status of the patient was only evident in a progress report dated 2012. There was no documenation of dynamic instability or degenerative spondylolisthesis on imaging reports to warrant fusion. Recent notes did not indicate the present smoking status of the patient. Given no comprehensive discussion concerning failure of conservative management and lack of information on current smoking status, the request for Anterior Lumbar Decompression And Interbody Arthrodesis of L4-5 and L5-S1 is not medically necessary.