

<b>Case Number:</b>	CM14-0004805		
<b>Date Assigned:</b>	01/24/2014	<b>Date of Injury:</b>	05/22/2003
<b>Decision Date:</b>	06/27/2014	<b>UR Denial Date:</b>	12/30/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	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, 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 patient is a 59 year old male who has submitted a claim for lumbar spinal stenosis with radiculopathy, sciatica, and lumbar disc displacement associated with an industrial injury date of May 22, 2003. Medical records from 2011 to 2013 were reviewed. The patient complained of constant, severe low back pain radiating to the bilateral lower extremities, associated with numbness and tingling sensation. The patient likewise has diabetes, hypertension, and hypercholesterolemia. Blood pressure was 135/71 mmHg with a pulse rate of 65 beats/min; derived body mass index was 27.4 kg/m<sup>2</sup>. Range of motion of the lumbar spine was 40% of normal. Muscle spasm and trigger points were present. The left extensor hallucis longus and gastrocnemius strength were graded 4/5. The left S1 reflex was absent. Sensation was diminished at the left lower extremity. The patient had a slow, antalgic gait, favoring the left lower extremity. He was unable to perform toe walk or heel walk at the left. An MRI of the lumbar spine, dated December 21, 2012, revealed minimal and diffuse disc bulge at L3 to L4, and L4 to L5 and mild bilateral facet hypertrophy; and neural foramina stenoses, mild to moderate on the left at L3 to L4 and L5 to S1, and on both sides at L4 to L5; no central canal stenosis. There was severe degenerative disc disease and stenosis at L4 to L5, as well as instability on flexion and extension x-rays at L4 to L5. Treatment to date has included lumbar epidural steroid injections, physical therapy, trigger point injections, and medications such as trazodone, Janumet, Glucotrol, simvastatin, lisinopril, Voltaren, tramadol, and aspirin. A utilization review from December 30, 2013 denied the request for lumbar decompression, laminectomy, discectomy, L4 to L5 and stabilization at L4 to L5, two to 3 day inpatient, Assistant surgeon, medical clearance because there was no adequate information as to the medical necessity of fusion at L4 to L5 since there was documentation of 3 level degenerative disc disease and pain generators have not been worked out. The other requests such as post op

aqua therapy for 12 sessions, home health care twice a week, and walker, back brace, and BioMet Stim were likewise denied because the surgical procedure was non-certified.

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

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

#### **POST OP AQUA THERAPY 2X6 =12: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: ACOEM PRACTICE GUIDELINES., ,

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines §9792.24.2, Page(s): 22-23.

**Decision rationale:** As stated on pages 22-23 of the MTUS Chronic Pain Guidelines, aquatic therapy is recommended as an alternative to land-based physical therapy where reduced weight bearing is desirable such as extreme obesity or fractures of the lower extremity. In this case, the patient has been certified to undergo lumbar decompression, laminectomy, discectomy, L4 to L5 and stabilization at L4 to L5. However, there was no indication why the patient could not participate in a land-based physical therapy program. His derived body mass index is 27.4 kg/m<sup>2</sup>; aquatic therapy is recommended only for extreme obesity. The medical necessity has not been established. Therefore, the request is not medically necessary.

#### **HOME HEALTH CARE TWICE A WEEK: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: ACOEM PRACTICE GUIDELINES. ,

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines X Chronic Pain Medical Treatment Guidelines, §§9792.20 - 9792.26, Page(s): 51.

**Decision rationale:** As stated on page 51 of the MTUS Chronic Pain Guidelines, home health services are only recommended for otherwise recommended medical treatment for patients who are homebound, generally up to no more than 35 hours per week. Medical treatment does not include homemaker services like shopping, cleaning, and laundry, and personal care given by home health aides like bathing, dressing, and using the bathroom when this is the only care needed. In this case, the patient has been certified to undergo lumbar decompression, laminectomy, discectomy, L4 to L5 and stabilization at L4 to L5. However, there is no clear indication in the medical records provided that the patient has a need of professional nursing services for the purposes of home health. Furthermore, the present request failed to specify the number of hours per day that the patient requires home health assistance. Therefore, the request is not medically necessary and appropriate.

#### **WALKER, BACK BRACE, BIOMET STIM.: Overturned**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: ACOEM PRACTICE GUIDELINES., ,

**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 Section, Walking aids; Low Back Section Back Brace, Post-operative (Fusion); Low Back Section, Bone Growth Stimulator

**Decision rationale:** Regarding the request for a walker, the Official Disability Guidelines states that disability, pain, and age-related impairments seem to determine the need for a walking aid, i.e., walker. In this case, patient has been certified to undergo lumbar decompression, laminectomy, discectomy, L4 to L5 and stabilization at L4 to L5. The patient will have some gait issues after surgery, and a walker is within guidelines that can be used to help him mobilize. Regarding the request for a back brace, Official Disability Guidelines states that back brace for postoperative use is under study, but given the lack of evidence supporting the use of these devices, a standard brace would be preferred over a custom post-op brace. Although there is a lack of data on outcomes, there may be a tradition in spine surgery of using a brace post-fusion. In this case, the patient has been certified to undergo lumbar decompression, laminectomy, discectomy, L4 to L5 and stabilization at L4 to L5. The patient will need a lumbar support post-surgery. The medical necessity has been established. Regarding Biomet Stim, Biomet device is an electrical bone growth stimulation device. The Official Disability Guidelines states that bone growth stimulation may be considered medically necessary as an adjunct to spinal fusion surgery for patients with any of the following risk factors for failed fusion: previous failed spinal fusion; grade III spondylolisthesis; fusion to be performed at more than one level; current smoking habit; diabetes, renal disease, alcoholism; or significant osteoporosis. In this case, patient has been certified to undergo lumbar decompression, laminectomy, discectomy, L4 to L5 and stabilization at L4 to L5. The patient likewise has diabetes with maintenance medications of Janumet and Glucotrol. The request is medically necessary and appropriate.

#### **LUMBAR DECOMPRESSION, LAMINECTOMY, DISCECTOMY, @L4-L5 AND STABILIZATION @L4-L5,: 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:** Regarding lumbar surgery, the 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 this case, the patient complained of chronic back pain radiating to both legs. This was corroborated by physical examination findings of restricted motion, weakness, hyporeflexia, and dysesthesia. Objective findings were confirmed by MRI results, dated December 21, 2012,

revealing minimal and diffuse disc bulge at L4 to L5 with neural foramina stenoses on both sides. There was severe degenerative disc disease and stenosis at L4 to L5, as well as instability on flexion and extension x-rays. He likewise failed conservative management consisting of physical therapy, lumbar epidural steroid injections, and medications. Given the patient's pain complaints, objective findings, imaging results and failure of conservative management the request is medically necessary and appropriate.

**2-3 DAY INPATIENT STAY:** 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 ODG

**Decision rationale:** Regarding hospital length of stay, the Official Disability Guidelines (ODG) states that the length of hospital stay (LOS) for discectomy is median of 1 day, and mean of 2.1 days. For lumbar laminectomy, the LOS median is 2 days, and mean of 3.5 days. For lumbar fusion, the LOS median is 3 days. In prospective management of cases, median is a better choice than mean. In this case, the surgical plan is lumbar decompression, laminectomy, discectomy, L4 to L5 and stabilization at L4 to L5. The request meets these criteria and is medically necessary and appropriate.

**ASSISTANT SURGEON:** 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 AMERICAN ACADEMY OF ORTHOPAEDIC SURGEONS

**Decision rationale:** Regarding assistant surgeon, the American Academy of Orthopaedic Surgeons states that the CPT code for laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disk; one interspace, lumbar (including open or endoscopically-assisted approach) is 63030. Assistant Surgery Guidelines indicated that an assistant surgeon is necessary for the aforementioned surgery. In this case, the surgical plan is lumbar decompression, laminectomy, discectomy, L4 to L5 and stabilization at L4 to L5. The request is medically necessary and appropriate.