

<b>Case Number:</b>	CM14-0019317		
<b>Date Assigned:</b>	04/21/2014	<b>Date of Injury:</b>	09/03/2009
<b>Decision Date:</b>	07/02/2014	<b>UR Denial Date:</b>	01/17/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/14/2014

### 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 Occupational Medicine, 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 49 year old female who was injured on 08/05/2009 who is a material handler who was climbing down from a step stool, lost her balance and fell backward injuring her lower back. Prior treatment history has included the patient undergoing post 2 level anterior and posterior fusion at L4-S1 on 05/03/2011. She is status post removal of hardware and posterolateral fusion of L4-L5 and L5-S1 with subsequent wound dehiscence, liquefied hematoma and drainage from the wound with possible infection. She has also had bilateral L3-L4 transforaminal epidural steroid injection on 11/26/2013. She has been through chiropractic care and prescribed a neck and back brace, heating pads, TENS unit and started on physical therapy. Diagnostic studies reviewed included MRI of the lumbar spine dated 01/26/2012 revealing the following: 1) There is status post prior surgical procedure seen at the L4-L5 through S1 levels with discectomies, laminectomies and posterior pedicle effusion. No recurrent disc protrusion is seen. No focal foraminal stenosis. 2) There is a loss of intervertebral disc height seen at the L3-L4 level with straightening of the normal lumbar spine. Lumbar lordosis is normal and there is no evidence of scoliosis or increased thoracic kyphosis. No paravertebral soft tissue abnormality. 3) L3-L4 annular concentric broad-based 3 mm disc protrusion is seen flattening and abutting the anterior portion of the thecal sac with mild bilateral spinal and neural foraminal stenosis. There is no extrusion or sequestration of the disc material. On 10/10/2013 a CT myelogram of the lumbar spine revealed the following: 1) Postsurgical changes related to L4-5 and L5-S1 discectomy and posterior fusion with interbody fixation device and interdisc cages. 2) Mild indentation of the anterior thecal sac at L3-4 due to broad based central disc protrusion and disc osteophyte complex. 3) Minimal osteophytic ridges noted in the left foramina of L2-3 level and at the L5-S1 foraminal levels bilaterally without neural impingement. 4) Otherwise, no stenosis identified at any level.

Progress note dated 12/12/2013 documented the patient with complaints of constant and incapacitating low back pain of 90% and right leg pain of 10% after the epidural steroid injection, with radiation to the lower extremities with associated numbness and tingling. She notes no improvement since the high volume epidural steroid injection at L3-L4 levels on 11/26/2013 by [REDACTED]. Objective findings on examination reveal the patient continues to experience diffuse tenderness and spasms. There is a positive sciatic notch tenderness. Straight leg raise test and tension signs are positive with symptoms between knee and the foot on the right side. There is weakness of the extensor hallucis longus and foot eversion on the right side. Diagnoses: 1. Status posterior lumbar spinal fusion at L4-S1 on 05/03/2011 performed by [REDACTED] rule out pseudo arthrosis. 2. Lumbar spine herniated nucleus pulposus at L3- 4. 3. Bilateral lower extremity radicular pain and paresthesias. 4. Worsening neurologic signs and symptoms. 5. Pseudoarthrosis at L4-L5 with hardware loosening. Progress note dated 03/31/2014 documented the patient with complaints of constant low back pain, rated 8/10, with radiation to the bilateral lower extremities, associated with numbness. She states that the pain radiates from the left side of the back to the buttocks. Moreover, she reports that she is unable to sit or stand or lay for long periods. Her current medications include Tylenol and topical creams. Objective findings on examination of the lumbar spine reveal paraspinal spasms and tenderness. The incision is clean, dry and intact. There is no drainage or erythema. In addition, there is no sciatica notch tenderness. Motor strength testing reveals weakness in the extensor hallucis longus and tibialis anterior muscle groups. Diagnosis: Status post removal of hardware and posterolateral fusion at L4-L5 and L5-S1 with subsequent wound dehiscence, liquefied hematoma and drainage from the wound with possible infection. UR report dated 01/17/2014 denied the request for referral to a vascular surgeon because posterior surgery does not require a vascular surgeon. The request for postoperative physical therapy to the spine, 24 visits was denied because the Post-Surgical Treatment Guidelines recommends an initial course of treatment of of recommended maximum number of postop physical therapy visits. Guidelines recommend up to 34 visits, therefore, initial course of physical therapy is partially certified for 17 visits. The request for rental of a hospital bed for 30 days was denied because the patient is a 49 year old individual without any significant comorbid condition that would require a hospital bed, per CMS guidelines. Medical necessity for a hospital bed for 30 days is not demonstrated. The request for a CT myelogram was denied because the patient has recently undergone a CT myelogram and repeat study is not medically necessary. The request for an MRI of the lumbar spine was denied as per the peer-to-peer with [REDACTED], an updated MRI is not felt to be medically necessary at this time.

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

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

**VASCULAR SURGEON QTY: 1.00: 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 Br J Neurosurg. 2012 Aug;26(4):499-503. Doi: 10.3109/02688697.2012.680629. Epub 2012 May 11. The Role Of The Vascular Surgeon In Anterior Lumbar Spine Surgery. <http://Www.Ncbi.Nlm.Nih.Gov/Pubmed/22577849>.

**Decision rationale:** CA MTUS and ODG do not specifically discuss the issue and hence other evidence-based literature was used. According to the referenced literature, "The anterior lumbar approach is not generally favored by many neurosurgeons, despite its many advantages, due to the significant risk of vascular injuries as reported in the literature. This risk is especially acknowledged by the emerging generation of neurosurgeons with very little general surgical exposure during the training years. Adopting a combined vascular and neurosurgical approach has been reported to reduce the risk of vascular injury in anterior lumbar surgery acceptably low. This team approach provides an excellent opportunity to preserve some key 'general' surgical skills for neurosurgeons and ensure safe outcome for the patients." According to the medical records, the patient has been authorized to undergo removal of hardware at L4-S1 with re-exploration of fusion/re-fusion and re-instrumentation, with assistant surgeon. The proposed surgery is reportedly a posterior lumbar spine surgery. There is no medical indication for a vascular surgeon in posterior lumbar surgery. Consequently, the request is not medically necessary.

**RENTAL OF A HOSPITAL BED (DAYS) QTY: 30.00:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation CMS, Coverage under Medicare.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 288. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back, Bed Rest, Hospital Length of Stay, and Non-MTUS Aetna: clinical policy bulletin - Hospital beds and accessories, [http://www.aetna.com/cpb/medical/data/500\\_599/0543.html](http://www.aetna.com/cpb/medical/data/500_599/0543.html).

**Decision rationale:** According to the medical records, the patient is an otherwise healthy 49 year old female that is pending revision lumbar fusion surgery. The guidelines advise that bed rest has potential debilitating effects; most patients do not require bed rest. Bed rest may lead to a slower recovery, however staying active and attempting to maintain activity levels is recommended. The medical records do not establish that the patient requires elevation in bed of greater than 30 degrees due to serious medical conditions such as congestive heart failure, chronic pulmonary disease, or aspiration. The medical records do not establish the patient requires positioning of the body in ways not feasible with an ordinary bed due to a medical condition that is expected to last a prolonged duration. The medical records do not provide a clinical rationale to establish justification for a hospital bed for the home. The medical necessity of this request for 30 day hospital bed rental is not established. With regard to hospitalization for 30 days, medical necessity is not established. ODG guidelines state that for posterior lumbar fusion mean hospital stay is 3.9 days. Best practice target is 3 days. Records do not establish exceptional circumstances that would require an extended length of stay and thus the request is not medically necessary.

**CT MYELOGRAM QTY: 1.00: 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), Low Back, Criteria for Myelography.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 304-305. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back, Myelography.

**Decision rationale:** According to the Official Disability Guidelines, CT Myelogram of the lumbar spine is not recommended except for selected indications, such as when MR imaging is contraindicated or inconclusive. The medical records document the patient had undergone a lumbar MRI in 01/26/2012, as well as has already undergone a recent lumbar CT myelogram on 10/10/2013. The medical records do not provide any evidence of significant change in subjective/objective findings that establishes a repeat study and thus the request is not medically necessary.

**MRI (UNSPECIFIED BODY PART) QTY: 1.00: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Page(s): 303.

**Decision rationale:** According to the CA MTUS/ACOEM guidelines, the criteria for ordering imaging studies are: Emergence of a red flag; physiologic evidence of tissue insult or neurologic dysfunction; failure to progress in a strengthening program intended to avoid surgery; and clarification of the anatomy prior to an invasive procedure. As stated, the patient underwent a lumbar MRI in January 2012, as well as recently underwent a lumbar CT myelogram in October 2013. The medical records do not demonstrate the existence of significant change in the patient's clinical presentation to warrant another imaging study. The recent CT myelogram has provided an adequate diagnostic assessment of the patient's lumbar spine. The request for MRI (Unspecified Body Part) is not medically necessary.

**POSTOPERATIVE PHYSICAL THERAPY TO THE SPINE QTY: 24: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Postsurgical Treatment Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 10, 24.

**Decision rationale:** The medical records demonstrate the patient has been recommended to undergo further lumbar spine surgery. In accordance with the CA MTUS postsurgical treatment guidelines, following this type of surgery, up to 34 visits over 16 weeks, during postsurgical physical medicine treatment period of 6 months, is recommended. The guideline state that in the "Initial course of therapy" one half of the number of visits specified in the general course of therapy for the specific surgery in the postsurgical physical medicine treatment recommendations, is appropriate and medically necessary, which is 17 sessions. Further therapy sessions would be dependent on documentation of the patient's response to the initial post-op course of therapy. The request is not medically necessary.

