

<b>Case Number:</b>	CM14-0158050		
<b>Date Assigned:</b>	10/01/2014	<b>Date of Injury:</b>	07/19/2013
<b>Decision Date:</b>	11/03/2014	<b>UR Denial Date:</b>	09/10/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/26/2014

### 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 Neurosurgeon and is licensed to practice in Georgia and Virginia. 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 injured worker is a 31-year-old female who reported an injury on 07/19/2013. The injured worker is an RN who was injured while lifting a patient and has been unable to work since that time. The injured worker's treatment history included pain medications, MRI studies, EMG/NCS, physical therapy, injections, and x-rays. The injured worker had undergone an MRI of the thoracic spine on 12/17/2013 that revealed there was degenerative disc disease, particularly at T10-11 and T11-12 levels, with mild exaggerated kyphosis centered at the T10 and T11 levels. At the T10-11 level, there was a 1 mm broad based disc bulge without significant central canal or foraminal stenosis. At the T11-12 level, there was a 3 mm to 4 mm broad based disc bulge slightly asymmetric to the left paracentral region, with mild effacement of the anterior thecal sac. There was no significant central canal or foraminal stenosis. No evidence of compression fracture. On 04/28/2014, the injured worker had undergone a thoracic epidural injection that was noted to have good results. The lumbar epidural injection did not give her any benefit. The injured worker had undergone an MRI of the thoracic spine on 05/28/2014 that revealed MRI prior from 12/17/2013, there has been essentially no significant interval change. Again noted was degenerative disc disease, particularly at T10-11 and T11-12 levels. It was noted that it was stable in comparison with the prior study with mild exaggerated kyphosis centered near the T11 level. The injured worker was evaluated on 09/02/2014 and it was documented the injured worker continued to have pain in her mid back. She stated nothing was helping her. She has tried rest, medications, physical therapy, and injection therapy without relief. She was seen by orthopedic surgeon who recommended surgical intervention for the injured worker. The orthopedic surgeon recommended a cervical fusion from T10-12 with decompression and fusion. Physical examination of the thoracolumbar spine revealed flexion was 60 degrees, extension, left/right rotation, left/right flexion were 0 degrees. There was 4+

thoracic spasm and tenderness, 4+ pain with range of motion. Her motor and sensory were stable. The injured worker was evaluated on 09/04/2014 and it was documented the injured worker's pain level still persists. The injured worker was taking oxycodone, but she was having to double up on the medication, taking about 8 tablets per day, which was adequately controlling her pain. She denied any significant radiating pain, but the pain levels are quite severe without medication and she was quite incapacitated by the pain. The physical examination of the thoracolumbar spine revealed tenderness along the lumbar paraspinals. Range of motion was limited to flexion to 9 degrees. Muscle strength was 5/5 in the upper and lower extremities. Diagnostic studies included thoracic degenerative disc disease, thoracic disc pathology at C11-C12, thoracic radiculitis, and lumbar disc pathology at L5-S1. Request for Authorization dated 09/03/2014 was for followup with pain management specialist and lumbar fusion, T10-11 and T11-12.

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

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

#### **Follow-up with a pain management specialist (lumbar/thoracic/pars stress) QTY: 1:**

Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG (Official Disability Guidelines); Pain Procedure Summary: Office visits

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG) Pain, Office Visit

**Decision rationale:** The request for continue pain management is not medically necessary. The Official Disability Guidelines recommend office visits for proper diagnosis and return to function of an injured worker. The need for a clinical office visit with a healthcare provider is individualized based upon a review of the patient's concerns, signs and symptoms, clinical stability, and reasonable physician judgment. As patients' conditions are extremely varied, a set number of office visits per condition cannot be reasonably established. The determination of necessity for an office visit requires individualized case review and assessment, being ever mindful that the best patient outcomes are achieved with the eventual patient independence from the healthcare system through self-care as soon as clinically feasible. The injured worker has ongoing pain symptoms in the mid back and low back. However, details pertaining to prior pain management treatments provided in the thoracic and lumbar spine are not outlined. Therefore, the request for followup with a pain management specialist (lumbar/thoracic/pars stress) QTY: 1 is not medically necessary.

#### **Lumbar fusion T10-11, T11-12: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 307.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG) Low, Fusion Spinal

**Decision rationale:** c) My rationale for why the requested treatment/service is or is not medically necessary: The requested is not medically necessary. According to Official Disability Guidelines (ODG) lumbar fusion are not recommended for patients who have less than six months of failed recommended conservative care unless there is objectively demonstrated severe structural instability and/or acute or progressive neurologic dysfunction, but recommended as an option for spinal fracture, dislocation, spondylolisthesis or frank neurogenic compromise, subject to the selection criteria outlined in the section below entitled. Prevent any movement in the intervertebral spaces between the fused vertebrae, thereby reducing pain and any neurological deficits. Lumbar fusion in workers' comp patients: In cases of workers' compensation, patient outcomes related to fusion may have other confounding variables that may affect overall success of the procedure, which should be considered. Until further research is conducted there remains insufficient evidence to recommend fusion for chronic low back pain in the absence of stenosis and spondylolisthesis, and this treatment for this condition remains "under study." It appears that workers' compensation populations require particular scrutiny when being considered for fusion for chronic low back pain, as there is evidence of poorer outcomes in subgroups of patients who were receiving compensation or involved in litigation. Despite poorer outcomes in workers' compensation patients, utilization is much higher in this population than in group health. Presurgical bio psychosocial variables predict patient outcomes from lumbar fusion, which may help improve patient selection. Workers' compensation status, smoking, depression, and litigation were the most consistent presurgical predictors of poorer patient outcomes. Other predictors of poor results were number of prior low back operations, low household income, and older age.) Obesity and litigation in workers' compensation cases predict high costs associated with interbody cage lumbar fusion. A recent study of 725 workers' comp patients in Ohio who had lumbar fusion found only 6% were able to go back to work a year later, 27% needed another operation, and over 90% were in enough pain that they were still taking narcotics at follow-up. A recent case-control study of lumbar fusion outcomes in worker's compensation (WC) patients concluded that only 9% of patients receiving WC achieved substantial clinical benefit compared to 33% of those not receiving WC. This large historical cohort study suggests that lumbar fusion may not be an effective operation in workers' compensation patients with disc degeneration, disc herniation, and/or radiculopathy, and it is associated with significant increase in disability, opiate use, prolonged work loss, and poor RTW status. After controlling for covariates known to affect lumbar fusion outcomes, patients on workers' comp have significantly less improvement.)