

Case Number:	CM14-0175414		
Date Assigned:	10/28/2014	Date of Injury:	05/01/2013
Decision Date:	12/12/2014	UR Denial Date:	10/10/2014
Priority:	Standard	Application Received:	10/23/2014

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:

This is a 44 year old female with a 5/1/13 injury date. While attempting to treat a patient, she was attacked and slammed into the floor, injuring her lower back. There was a recent authorization for a revision micro lumbar decompressive surgery at left L5-S1 on 1/31/14, but the patient declined and sought a third opinion. In a QME report on 7/23/14, the provider felt that the most appropriate option would be to redo a discectomy and interbody fusion at L5-S1 because a redo discectomy alone would not provide much benefit. In a 9/26/14 follow-up, the patient continues to have 7/10 back pain, experiences continued severe back and left leg symptoms and increasing right leg symptoms. Objective findings included a mildly antalgic gait, tenderness over the paraspinal muscles, pain on lumbar extension, decreased sensation in the L4 dermatome on the left. Strength testing was 4/5 left tibialis anterior (TA), extensor hallucis longus (EHL), inversion, eversion, plantar flexion, quadriceps, and hamstring. There was 4+/5 strength in the right TA, EHL, inversion, and eversion. The patellar and Achilles reflexes were hyper-reflexive bilaterally. There was a positive straight leg raise test bilaterally at 60 degrees. A 9/10/14 lumbar MRI showed L5-S1 disc dessication with annular fissure, bilateral L5-S1 laminectomy changes, and broad-based disc herniation at L5-S1 without significant canal stenosis or neural foraminal narrowing. A 9/9/13 electrodiagnostic study showed evidence of left S1 radiculopathy. Lumbar x-rays with flexion and extension views on 4/18/14 showed a possible grade I retrolisthesis at L5-S1 without any movement upon flexion or extension. A 12/16/13 lumbar MRI report is available which shows L5-S1 retrolisthesis. Diagnostic impression: lumbar spondylolisthesis, lumbar radiculopathy. Treatment to date: ice application, walking, swimming, physical therapy, chiropractic care, acupuncture, epidural steroid injection, medications, microlumbar discectomy in 2010 that was prior to the current injury, left sacroiliac joint injection. A UR decision on 10/10/14 denied the request for posterior lumbar fusion with

transforaminal interbody fusion (TLIF) and decompression at L5-S1 on the basis that there is no formal x-ray report of the flexion and extension views showing retrolisthesis. The requests for medical clearance, lab work, hydrocodone, cyclobenzaprine, office follow-up visit, and post-op rehabilitation were denied because the associated surgical procedure was not certified.

IMR ISSUES, DECISIONS AND RATIONALES

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

Posterior Lumbar Spinal Fusion with transforaminal interbody fusion and decompression at L5 - S1: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-307.

Decision rationale: CA MTUS states that surgical intervention is recommended for patients who have severe and disabling lower leg symptoms in the distribution consistent with abnormalities on imaging studies (radiculopathy), preferably with accompanying objective signs of neural compromise; activity limitations due to radiating leg pain for more than one month or extreme progression of lower leg symptoms; clear clinical, imaging, and electrophysiologic evidence of a lesion that has been shown to benefit in both the short and long-term from surgical repair; and failure of conservative treatment. In addition, CA MTUS states that there is no good evidence from controlled trials that spinal fusion alone is effective for treating any type of acute low back problem, in the absence of spinal fracture, dislocation, or spondylolisthesis if there is instability and motion in the segment operated on. In this case, both the 2014 lumbar x-ray and 2013 lumbar MRI show grade 1 listhesis at L5-S1. Although there was no movement of L5 on S1 seen on the flexion/extension views, the fact that the patient has already had a discectomy at L5-S1 would increase the likelihood of micro-instability at this level. On this basis, I would agree with the treatment provider in that a repeat discectomy alone is not likely to benefit this patient. In addition, the patient exhibits symptoms and signs of radiculopathy with motor, sensory, and reflex dysfunction present on physical exam. Overall, the medical necessity of the proposal appears to be established. Therefore, the request for Posterior Lumbar Spinal Fusion with transforaminal interbody fusion and decompression at L5 - S1 is medically necessary.

Associated surgical service: Pre Operative Medical Clearance including Medical Consult:
Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Chapter 7 Independent Medical Examinations and Consultations, page 127

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical

Evidence: ACC/AHA 2007 Guidelines on perioperative cardiovascular evaluation and care for noncardiac surgery

Decision rationale: CA MTUS does not address this issue. The ACC/AHA 2007 Guidelines on perioperative cardiovascular evaluation and care for noncardiac surgery state that in the asymptomatic patient, a more extensive assessment of history and physical examination is warranted in those individuals 50 years of age or older. However, this is a 44 year old patient with no documented medical comorbidities. Therefore, the request for associated surgical service: Pre Operative Medical Clearance including Medical Consult is not medically necessary.

Associated surgical service: Pre Operative Lab Works - Chem Panel, CBC, UA, APTT, PT, T&S, EKG and Chest X-Ray: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Treatment for Workers Compensation, last updated 08/22/2014 - Preoperative testing

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--Pre operative EKG and Lab testing

Decision rationale: CA MTUS does not address this issue. ODG states that pre-op testing can be helpful to stratify risk, direct anesthetic choices, and guide postoperative management, but often are obtained because of protocol rather than medical necessity. The decision to order preoperative tests should be guided by the patient's clinical history, comorbidities, and physical examination findings. Patients with signs or symptoms of active cardiovascular disease should be evaluated with appropriate testing, regardless of their preoperative status. Electrocardiography is recommended for patients undergoing high-risk surgery and those undergoing intermediate-risk surgeries who have additional risk factors. Patients undergoing low-risk surgery do not require electrocardiography. Chest radiography is reasonable for patients at risk of postoperative pulmonary complications if the results would change perioperative management. Given that the requested surgery is intermediate-risk, the requested studies are appropriate. Therefore, the request for associated surgical service: Pre Operative Lab Works - Chem Panel, CBC, UA, APTT, PT, T&S, EKG and Chest X-Ray is medically necessary.

Associated surgical service: Hydrocodone/APAP 5/325mg #30: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, specific drug list Page(s): 78-80, 91, 124.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment Page(s): 47-48, Chronic Pain Treatment Guidelines Page(s): 79-81.

Decision rationale: CA MTUS states that opioids appear to be no more effective than safer analgesics for managing most musculoskeletal and eye symptoms; they should be used only if needed for severe pain and only for a short time, such as in a postoperative setting. The requested

dosage and amount of hydrocodone is reasonable and appropriate. Therefore, the request for associated surgical service: Hydrocodone/APAP 5/325mg #30 is medically necessary.

Associated surgical service: Cyclobenzaprine 7.5mg #30: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain) Page(s): 63-64.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants Page(s): 41-42.

Decision rationale: According to page 41 of the CA MTUS Chronic Pain Medical Treatment Guidelines, Cyclobenzaprine is recommended as an option, using a short course of therapy. The effect is greatest in the first 4 days of treatment, suggesting that shorter courses may be better. Treatment should be brief. There is also a post-op use. The addition of cyclobenzaprine to other agents is not recommended. The requested dosage and amount of cyclobenzaprine implies short-term treatment and is therefore appropriate in the post-op period after spine surgery. Therefore, the request for associated surgical service: Cyclobenzaprine 7.5mg #30 is medically necessary.

Associated surgical service: Office follow up visit: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Chapter 7 Independent Medical Examinations and Consultations, page 127

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG): Pain Chapter-- Office visits

Decision rationale: CA MTUS does not address this issue. ODG states that evaluation and management (E&M) outpatient visits to the offices of medical doctor(s) play a critical role in the proper diagnosis and return to function of an injured worker, to monitor the patient's progress, and make any necessary modifications to the treatment plan. 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 eventual patient independence from the health care system through self-care as soon as clinically feasible. In this case, follow-up with the treatment provider in the post-op period is appropriate. Therefore, the request for associated surgical service: Office follow up visit is medically necessary.

Associated surgical service: Post Operative Chiropractic rehabilitative visits 2 times a week for 6 weeks to the lumbar spine.: Overturned

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

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment Guidelines.

Decision rationale: CA MTUS recommends 34 physical therapy sessions over 16 weeks after lumbar fusion. The request for 12 sessions of physical therapy is within the guideline criteria and is appropriate. Therefore, the request for associated surgical service: Post Operative Chiropractic rehabilitative visits 2 times a week for 6 weeks to the lumbar spine is medically necessary.