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| Case Number: | CM14-0025779 | | |
| Date Assigned: | 06/13/2014 | Date of Injury: | 08/21/2012 |
| Decision Date: | 07/29/2014 | UR Denial Date: | 02/17/2014 |
| Priority: | Standard | Application Received: | 02/28/2014 |

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 Texas. 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 60 year old male who sustained an injury on 08/21/12 when he was involved in a motor vehicle accident. The injured worker was rear ended at a stop sign and developed complaints of low back pain. Prior surgical intervention has included an L3 through S1 lumbar decompression in February of 2012. This surgery occurred before the date of injury. The injured worker had been doing well following the surgical intervention until the motor vehicle accident occurred. Prior treatment included three separate epidural steroid injections with only temporary relief of symptoms. The injured worker described weakness in the lumbar spine with ambulation. The injured worker described having difficulty with heel and toe walking. The injured worker was also treated with muscle relaxers as well as a topical medication for pain. Radiographs of the lumbar spine taken in office were reported to show prior laminectomy defects from L3 through S1 with disc space narrowing at all three levels and maintenance of the usual lumbar lordosis. No improvements were reported with ongoing physical therapy. MRI studies of the lumbar spine from 12/27/13 noted left sided laminectomy defects at L3-4 and L4-5. There was enhancing scar tissue noted centrally with a two millimeter disc bulge at the annulus. There was minimal foraminal stenosis noted at L3-4. At L4-5, there was disc desiccation and disc space narrowing. Adequate decompression of the L5 lateral recess was identified. There was a residual three millimeter left sided foraminal bulge and minimal extrusion contributing to minimal to moderate left subarticular recess and proximal L4 foraminal stenosis. Electrodiagnostic studies from 03/12/14 did note evidence of a left L5 chronic radiculopathy. The injured worker's physical examination findings demonstrated weakness at the left extensor hallucis longus and anterior tibialis. It is noted in the clinical record the injured worker had a prior foot drop before the index decompression procedures prior to the date of injury. The requested anterior lumbar interbody fusion with autograft, allograft, synthetic graft, bone marrow

aspiration, and instrumentation at L3-4 and L4-5 with neuromonitoring as well as a two day inpatient length of stay, assistant surgeon, preoperative clearance, bone growth stimulator, postoperative lumbar brace, aquatic physical therapy, and land based physical therapy were all denied by utilization review on 02/17/14.

IMR ISSUES, DECISIONS AND RATIONALES

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

DAY 1: ANTERIOR LUMBAR INTERBODY FUSION, RETROPERITONEAL OR FA5R LATERAL APPROACH, AUTOGRAFT, ALLOGRAFT, SYNTHETIC GRAFT, BONE MARROW ASPIRATION, INSTRUMENTATION, ILIAC CREST BONE GRAFT, L3-L4 AND L4-L5 NEUROMONITORING (TURELL): 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 Chapter, intraoperative monitoring.

Decision rationale: In regard to the requests for the anterior lumbar interbody fusion with instrumentation and bone grafting with neuromonitoring, this request is not medically necessary based on review of the clinical documentation submitted as well as current evidence based guidelines. Imaging of the lumbar spine at L3-4 and L4-5 noted postoperative changes without evidence of recurrent disc herniations at either level. There was no clear evidence of any ongoing nerve root compression reasonably contributing to active radiculopathy versus the chronic findings reported on the record stemming from the previous decompression procedures before the date of injury. There was no evidence of any instability at either L3-4 or L4-5 that would have supported surgical intervention for this injured worker. Although the injured worker remains symptomatic despite conservative treatment, without evidence of instability, severe spondylolisthesis, or any complete collapse of the disc spaces at L4-5 or at L3-4, guidelines would not recommend the proposed lumbar fusion procedures. Furthermore, the clinical documentation did not include a preoperative psychological consult ruling out any confounding issues that would possibly impact postoperative recovery as recommended by guidelines. As the clinical documentation submitted for review did not meet guideline recommendations regarding the proposed procedures, this reviewer would not have recommended the request as medically necessary. As the surgical requests for the injured worker were not felt to be medically appropriate, the requested neuromonitoring for this injured worker would not have been supported as medically necessary.

DAY 2: L3-L4 AND L4-L5 INSTRUMENT FUSION, ALLOGRAFT6, BONE MARROW ASPIRATION 2-3 NIGHT 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 Chapter, Inpatient hospitalization.

Decision rationale: In regards to the requests for the L3-4 and L4-5 instrumented fusion with allograft, bone marrow aspiration, and a 2-3 day length of stay; this request is not medically necessary based on review of the clinical documentation submitted as well as current evidence based guidelines. Imaging of the lumbar spine at L3-4 and L4-5 noted postoperative changes without evidence of recurrent disc herniations at either level. There was no clear evidence of any ongoing nerve root compression reasonably contributing to active radiculopathy versus the chronic findings reported on the record stemming from the previous decompression procedures before the date of injury. There was no evidence of any instability at either L3-4 or L4-5 that would have supported surgical intervention for this injured worker. Although the injured worker remains symptomatic despite conservative treatment, without evidence of instability, severe spondylolisthesis, or any complete collapse of the disc spaces at L4-5 or at L3-4, guidelines would not recommend the proposed lumbar fusion procedures. Furthermore, the clinical documentation did not include a preoperative psychological consult ruling out any confounding issues that would possibly impact postoperative recovery as recommended by guidelines. As the clinical documentation submitted for review did not meet guideline recommendations regarding the proposed procedures, this reviewer would not have recommended the request as medically necessary. As the surgical requests for the injured worker were not felt to be medically appropriate, the requested 2-3 day length of stay for this injured worker would not have been supported as medically necessary.

ASSISTANT SURGEON: 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 Other Medical Treatment Guideline or Medical Evidence: American Association of Orthopaedics Surgeons Position Statement Reimbursement of the First Assistant at Surgery in Orthopaedics.

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

PREOPERATIVE CLEARANCE: 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 Official Disability Guidelines (ODG) Low Back Chapter, Pre-operative testing, general.

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

BONE STIMULATOR: 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 Official Disability Guidelines (ODG) Low Back Chapter, bone growth stimulator.

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

TRIMOD BRACE: 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 Official Disability Guidelines (ODG) Low Back Chapter, Back Brace, Post-operative Fusion.

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

AQUATIC PHYSICAL THERAPY 2 TIMES A WEEK FOR 4 WEEKS: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Aquatic Therapy Page(s): 22.

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

LAND PHYSICAL THERAPY 2 TIMES A WEEK FOR 6 WEEKS: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 26.

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