MAXIMUS Federal Services

Case Number:	CM14-0066371		
Date Assigned:	07/11/2014	Date of Injury:	06/20/1994
Decision Date:	08/08/2014	UR Denial Date:	04/25/2014
Priority:	Standard	Application Received:	05/09/2014

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 Orthopaedic 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 71-year-old male sustained an industrial injury on 6/20/94. Injury occurred during a serious roll-over truck accident. Past surgical history was positive for cervical fusion, and upper extremity, hip, knee, and foot surgeries with multiple post-operative staph injections. Failure of comprehensive conservative treatment has been documented over the past couple of years with progressive worsening. The 2/4/14 lumbar spine MRI impression documented moderate to severe central stenosis L3/4 and L4/5 secondary to multifactorial acquired degenerative changes. There was grade 1 anterolisthesis L5 on S1 secondary to chronic bilateral L5 pars defects. There was a right paracentral L3/4 disc protrusion with superior extrusion of disc material and moderate mass effect upon the right thecal sac. The 3/28/14 spine surgery report cited severe lower back pain with intermittent lower extremity pain, but mostly localized in the low back. There was increased pain with prolonged walking, standing or sitting. Pain was decreased with lying down and medication. Physical exam documented antalgic gait, ability to heel/toe raise, slight bilateral L4 weakness, and decreased left L4 and bilateral L5 dermatomal sensation. The patient had CT scan and MRI what showed severe lumbar stenosis with instability from L3 to S1. The patient failed all non-operative conservative therapies. Authorization was requested for L3 to S1 posterior decompression with lateral gutter fusion, as well as an L5/S1 lumbar interbody fusion. Additional durable medical equipment and post-operative services were ordered. The addendum noted stenosis at L3/4 and L4/5 with spondylolisthesis at L5/S1. There was a high sacral take off and the significant lumbar lordosis. There appeared to be retrolisthesis at the L4/5. There was stenosis and translational instability that required decompression and fusion from L3 to S1. The 4/25/14 utilization review modified the request for L3-S1 posterior decompression and fusion and L5/S1 lumbar interbody fusion and approved L3-S1 posterior decompression and L5/S1 lumbar interbody fusion. There was limited objective evidence of

instability at L3-L5 to justify fusion at these levels. The request for ice machine was denied based on limited evidence to support a cold therapy unit over cold packs. The request for bone stimulator was denied as there were no risk factors of failed fusion.

IMR ISSUES, DECISIONS AND RATIONALES

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

Surgery, L3-S1 posterior decompression and L5-S1 lumbar interbody fusion: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 306, 307,Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation ODG-TWC, Low back.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 202-211. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back - Lumbar & Thoracic, Discectomy/Laminectomy, Fusion (spinal).

Decision rationale: The ACOEM Revised Low Back Disorder guidelines recommend decompression surgery as an effective treatment for patients with symptomatic spinal stenosis (neurogenic claudication) that is intractable to conservative management. Lumbar fusion is not recommended as a treatment for spinal stenosis unless concomitant instability has been proven. The Official Disability Guidelines recommend criteria for lumbar discectomy and laminectomy that include symptoms/findings that confirm the presence of radiculopathy and correlate with clinical exam and imaging findings. Fusion may be supported for surgically induced segmental instability but pre-operative guidelines recommend completion of all physical medicine and manual therapy interventions and psychosocial screen with all confounding issues addressed. Guideline criteria have not been met. There are no detailed flexion/extension films evidencing guideline-associated segmental instability. There is no evidence of a psychosocial screen as required by guidelines. Therefore, this request for L3-S1 posterior decompression and L5-S1 lumbar interbody fusion was not medically necessary.

Ice machine, purchase: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300. Decision based on Non-MTUS Citation ODG-TWC, DME (durable medical equipment), Low back.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 160-161.

Decision rationale: As the request for lumbar spinal surgery was not medically necessary, the request for ice machine purchase is also not medically necessary.

Bone stimulator, purchase: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG-TWC, Low back.

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 - Lumbar & Thoracic, Bone growth stimulators (BGS.

Decision rationale: As the request for lumbar spinal surgery was not medically necessary, the request for bone stimulator purchase is also not medically necessary.

Home health post-operative care: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Home health services, page(s) 51 Page(s): 51.

Decision rationale: As the request for lumbar spinal surgery was not medically necessary, the request for home health post-operative care is also not medically necessary.

Inpatient stay: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG-TWC, Low back, hospital length of stay.

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 - Lumbar & Thoracic, Hospital length of stay (LOS).

Decision rationale: As the request for lumbar spinal surgery was not medically necessary, the request for inpatient stay is also not medically necessary.