

Case Number:	CM14-0094195		
Date Assigned:	07/25/2014	Date of Injury:	06/17/2009
Decision Date:	12/02/2014	UR Denial Date:	06/12/2014
Priority:	Standard	Application Received:	06/20/2014

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 58 year old female with a date of injury on 6/17/2009. Injury occurred while lifting a box. She underwent L4/5 laminectomy and fusion surgery on 8/18/09 with residual chronic pain. The 1/23/12 bilateral lower extremity electrodiagnostic study demonstrated findings consistent with right L4, L5 and S1 and left L5 and S1 radiculopathy. The 1/13/14 treating physician report indicated that the worker was working and had been treated recently with acupuncture and Motrin. The treatment plan documented recommendations for soft tissue modalities, exercise, activity modification, acupuncture, and medications. The 2/11/14 lumbar spine magnetic resonance imaging scan impression documented a hemilaminectomy defect on the right at the L4/5 level with associated soft tissue changes. The L4/5 and L5/S1 discs were desiccated and reduced in height. There was Modic type II degenerative endplate marrow changes at L4/5 and vertebral body hemangiomas at T11 and L4. There was an L2/3 diffuse concentric posterior annular disc bulge and L3/4 facet joint arthrosis and ligamentum flavum hypertrophy. There was an epidural disc abnormality at L4/5 which might represent a disc protrusion or fibrosis, and facet joint arthrosis and ligamentum flavum hypertrophy with mild to moderate neuroforaminal narrowing, greater on the right, and mild lateral recess stenosis. There was an L5/S1 focal central disc protrusion, facet joint arthrosis, ligamentum flavum hypertrophy, and mild bilateral neuroforaminal narrowing with encroachment of the left exiting nerve root. The 6/2/14 treating physician report cited complaints of lumbar spine pain, tenderness, limited motion, and weakness with pain radiating into both buttocks and thighs. There was pain, numbness and tingling radiating into the left lower extremity. Symptoms were worse with activity and somewhat relieved with rest. Mechanical low back pain was more troublesome than radicular pain. Current medications included Motrin as needed. Physical exam documented height 5'0", weight 190 pounds, antalgic short step gait, and low back tenderness,

spasms, and tightness. Range of motion was reduced with pain to flexion 20, extension 5, and right/left lateral flexion 10 degrees. Difficulty was noted with sciatic stretch. There was weakness in heel/toe walk. The diagnosis was L4/5 and L5/S1 discopathy, status post L4/5 microdiscectomy. The treating physician indicated that trials of rest, time off work, therapy, medications and all other conservative methods had failed. The injured worker had panic issues that precluded epidural steroid injections. The treatment plan recommended 2-level fusions at L4/5 and L5/S1 with associated surgical requests. The 6/12/14 utilization review denied the L4/5 and L5/S1 posterior lumbar interbody fusion and associated requests as there was no documentation of a recent trial of physical therapy or chiropractic treatment or a psychological evaluation with surgical clearance.

IMR ISSUES, DECISIONS AND RATIONALES

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

L4-5, L5-S1 PLIF (posterior lumbar interbody fusion): Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation ODG, Low back chapter, Fusion (spinal)

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-310. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back - Lumbar & Thoracic (Acute & Chronic), Fusion (spinal)

Decision rationale: The Chronic Pain Medical Treatment Guidelines state that lumbar fusion is not recommended as a treatment for workers with radiculopathy from disc herniation or for workers with chronic lower back pain after lumbar discectomy. The Official Disability Guidelines state that spinal fusion is not recommended for workers 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. Fusion is recommended for objectively demonstrable segmental instability, such as excessive motion with degenerative spondylolisthesis. Pre-operative clinical surgical indications require completion of all physical therapy and manual therapy interventions, x-rays demonstrating spinal instability, spine pathology limited to 2 levels, and psychosocial screening with confounding issues addressed. Guideline criteria have not been met. This injured worker has persistent back pain status post lumbar microdiscectomy. There is no evidence of acute or progressive neurologic dysfunction. There is no radiographic evidence of segmental instability. A psychosocial clearance is not evidenced. While the treating physician had noted that the injured worker has failed conservative treatment, detailed evidence of recent, reasonable comprehensive treatment, including physical therapy or manual therapy interventions, has not been documented. Therefore, this request is not medically necessary.

Associated surgical service: Post-operative physical therapy, two (2) times a week for four (4) weeks: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation ODG, Low back chapter, Fusion (spinal)

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.

Associated surgical service: Two (2) day hospital stay: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation ODG, Low back chapter, Fusion (spinal)

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 (Acute & Chronic), Hospital length of stay (LOS)

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

Associated surgical service: Post-operative evaluation by RN (Registered Nurse) after first twenty-four (24) hours when patient is at home: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation ODG, Low back chapter, Fusion (spinal)

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

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

Sprix nasal spray 15.75 mg, 40 units, five (5) bottles: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation ODG, Low back chapter, Fusion (spinal)

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain (Chronic), Sprix (ketorolac tromethamine nasal spray)

Decision rationale: As the surgical request is not supported, this request is not medically necessary.

Associated surgical service: Lumbar spine orthosis: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation ODG, Low back chapter, Fusion (spinal)

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 298-303.

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

Associated surgical service: Front wheel walker: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation ODG, Low back chapter, Fusion (spinal)

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee & Leg (Acute & Chronic), Walking aids (canes, crutches, braces, orthoses, & walkers)

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

Associated surgical service: Commode, 3 in 1: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation ODG, Low back chapter, Fusion (spinal)

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee & Leg (Acute & Chronic), Bathtub seats, Durable medical equipment

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

Associated surgical service: Ice unit: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation ODG, Low back chapter, Fusion (spinal)

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 298-301.

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

Associated surgical service: Bone stimulator: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation ODG, Low back chapter, Fusion (spinal)

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 (Acute & Chronic), Bone growth stimulators (BGS)

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

Associated surgical service: Home help (duration/frequency determined post-operatively):
Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation ODG, Low back chapter, Fusion (spinal)

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

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