

<b>Case Number:</b>	CM14-0188019		
<b>Date Assigned:</b>	11/18/2014	<b>Date of Injury:</b>	08/09/2011
<b>Decision Date:</b>	01/06/2015	<b>UR Denial Date:</b>	10/31/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/11/2014

### 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 48-year-old male who reported an injury on 08/09/2011, due to an unspecified mechanism of injury. On 10/07/2014, he presented for an evaluation. He reported radiating pain into the right lower extremity. A physical examination showed that he was in no acute distress, and cardiac, pulmonary, and GI examinations were all normal. His spinal examination showed pain with extension and rotation, he had positive paraspinal spasm and decreased range of motion to the lumbar spine. There was some restriction in range of motion of the lumbar spine with extension and rotation, and he had tenderness to palpation with sciatic notch pain. There was also a mildly decreased cadence and stride length. A lumbar spine MRI dated 02/10/2014, showed a disc desiccation with a 2 to 3 mm right sided disc protrusion at the L4-5 level that flattened the ventral aspect of the thecal sac and abutted but did not compress the emerging right L5 nerve root within the thecal sac, along with a disc desiccation with a 2 to 3 mm right sided disc protrusion noted at the L5-S1 level, that abutted but did not compress the descending S1 nerve root within the spinal canal. Previous treatments included injections and activity modifications. He was diagnosed with disc degeneration of the lumbar spine, facet arthropathy, and status post failure of all conservative treatment. Information regarding the injured worker's surgical history and medications was not provided for review. The treatment plan was for an anterior posterior lumbar interbody fusion at the L4-5 and L5-S1, 2 assistant surgeons, an inpatient stay for 2 to 3 days, preoperative labs, an EKG, a chest x-ray with preoperative clearance, home health aide services 2 to 3 hours a day, 2 to 3 times for 4 weeks, an RN evaluation for wound check, outpatient postoperative physical therapy 2x4, postoperative home health physical therapy 2x3, a commode, and a walker. The Request for Authorization form was signed on 11/04/2014. The rationale for treatment was not provided.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Home Health aide services 2-3 hrs/day, 2-3 week x 4 weeks:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 51. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

**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, Home Health Services.

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

**Anterior/Posterior lumbar inter body fusion at L4-5, L5-S1:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-306. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) and AMA Guides to the Evaluation of Permanent Impairment, pg. 379

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 307. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back, Fusion.

**Decision rationale:** The request for an anterior posterior lumbar interbody fusion at the L4-5 and L5-S1 is not medically necessary. The CAMTUS/ACOEM guidelines state that injured workers with increased spinal instability after surgical decompression at the level of degenerative spondylolisthesis may be candidates for fusion. The Official Disability Guidelines state that fusions are not recommended for those who have not failed at least 6 months of recommended conservative care. There should also be instability demonstrated on imaging studies and evidence of a psychosocial screen. While the injured worker was noted to be symptomatic regarding the lumbar spine, there was a lack of documentation showing that the injured worker had undergone at least 6 months of recommended conservative care, such as physical therapy, to indicate the need for a fusion. There is also no documentation showing that the he had undergone a psychosocial screen and, without this information, the request would not be supported. Given the above, the request is not medically necessary.

**Assistant Surgeons x 2 (one for the anterior and one for the posterior):** 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, Surgical assistant.

**Decision rationale:** The request for assistant surgeons x2 is not medically necessary. The CAMTUS/ACOEM Guidelines do not address surgical assistants. The Official Disability Guidelines state that surgical assistants are recommended as an option in more complex surgeries. Only one assistant surgeon for each procedure is a reimbursable service. While the concurrent surgical request for a fusion would require 1 assistant surgeon, 2 assistant surgeons would be excessive and would not be supported by the guidelines. In addition, the concurrent surgical request was not supported by the clinical documentation and, therefore, the requested assistant surgeon would not be indicated. Given the above, the request is not medically necessary.

**Inpatient stay 2-3 days:** Upheld

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

**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, Hospital Length of stay.

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

**Pre-op Labs (CMP, PT, PTT, CBC, UA):** Upheld

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

**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, Preoperative lab testing.

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

**EKG:** Upheld

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

**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, ECG.

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

**CXR with pre-op clearance: Upheld**

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

**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, Preoperative testing.

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

**RN evaluation for wound check: 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, Home Health Services.

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

**Outpatient post-op physical therapy 2 x 4: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Postsurgical Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

**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.

**Post-op Home Health physical therapy 2 x 4: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Postsurgical Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

**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.

**Commode:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation The Medicare National Coverage Determinations Manual

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee and Leg, Durable Medical Equipment.

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

**Walker:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation The Medicare National Coverage Determinations Manual

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee and Leg, Walking aids.

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

**LSO Back Brace:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 301. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

**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 supports.

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