

Case Number:	CM15-0000923		
Date Assigned:	02/13/2015	Date of Injury:	07/03/2010
Decision Date:	04/01/2015	UR Denial Date:	12/22/2014
Priority:	Standard	Application Received:	01/05/2015

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
 State(s) of Licensure: Illinois, California, Texas
 Certification(s)/Specialty: Orthopedic Surgery

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 53-year-old male who sustained an industrial injury on 7/3/10. Injury occurred relative to heavy lifting. Past medical history was positive for bladder problems. He underwent L4-S1 lumbar decompression and fusion on 10/7/11. The 7/17/14 lumbar spine MRI impression documented degenerative disc and joint disease with postsurgical change consistent with L4 to S1 laminectomies and fusion with instrumentation. At L3/4, there was a 6 mm posterior disc protrusion with mild to moderate spinal stenosis and suspected impingement of the L4 nerve roots in the lateral recess. At L5/S1, there was a 2 mm posterior disc bulge with suspected impingement of the right L5 nerve root at the right neural canal. The 12/3/14 treating physician report cited increasing back and bilateral lower extremity pain, right greater than the left. There was increasing right lower extremity numbness. Epidural steroid injection had been provided at L3/4 bilaterally without relief. The physical exam revealed 4+/5 right quadriceps weakness and decreased sensation over the right posterolateral calf. He ambulated with a forward flexed posture with a slight antalgic gait on the right. X-rays showed a slight list to the left side and posterior fixation extending from L4 to S1 with PEEK spacers at L4/5 and L5/S1 in appropriate position and findings of solid fusion. There was increased angulation at L3/4 with retrolisthesis. Flexion/extension films showed no gross transitory instability. MRI findings showed a large disc extrusion at L3/4 with severe stenosis. The treating physician noted the patient had failed additional conservative treatment. There was severe stenosis at L3/4 with significant neurologic deficits that were progressing. The treatment plan included a L3-S1 PSF (posterior spinal fusion)/PSI posterior spinal instrumentation) and a L3/4 TLIF (transforaminal

interbody fusion). The 12/22/14 utilization review non-certified the requests for island bandages, physical therapy, an inpatient stay for 3 days, an external bone growth stimulator, a lumbar brace, a surgical assistant, a L3-S1 PSF/PSI, a L3/4 TLIF, and remove and explore based on lack of a CT scan to assess fusion mass (where there is evidence of non-union or other fusion failure signs) to justify revision fusion of exploration from L 4 to S1. The California Medical Treatment Utilization Schedule (MTUS): Postsurgical Treatment Guidelines and ACOEM (American College of Occupational and Environmental Medicine) Guidelines, and the Official Disability Guidelines (ODG) were cited. The 12/29/14 treating physician report indicated the patient had on-going back pain. The urologist noted cauda equina syndrome. Due to the progressive neurologic deficits and severe stenosis in L3/4, surgery was appealed. On 1/5/15, the injured worker submitted an application for IMR.

IMR ISSUES, DECISIONS AND RATIONALES

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

Associated service: One box island bandage: 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 Lumbar & Thoracic: Wound dressings.

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

Associated service: Eighteen physical therapy: 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: As the surgical request is not supported, this request is not medically necessary.

Associated service: Inpatient stay for three days: 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 Lumbar & Thoracic: Hospital length of stay (LOS).

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

Associated service: Lumbar 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 American College of Occupational and Environmental Medicine (ACOEM). Occupational Medical Practice Guidelines 2nd Edition. Chapter 12 Low Back Disorders. (Revised 2007) page(s) 138-139.

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

Associated service: External bone growth 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 Lumbar & Thoracic: Bone growth stimulators (BGS).

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

Associated service: Surgical assistant: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation AAQS Position Statement Reimbursement Of The First Assistant At Surgery In Orthopaedics.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Low Back Lumbar & Thoracic: Surgical assistant.

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

L3-S1 PSF/PSI: Upheld

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): 307. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Lumbar & Thoracic: Fusion (spinal).

Decision rationale: The California MTUS guidelines indicate that lumbar spinal fusion may be considered for patients with increased spinal instability after surgical decompression at the level of degenerative spondylolisthesis. Guidelines state there was no good evidence that spinal fusion alone was effective for treating any type of acute low back problem, in the absence of spinal fracture, dislocation, or spondylolisthesis if there was instability and motion in the segment operated on. The guidelines recommend that clinicians consider referral for psychological screening to improve surgical outcomes. The Official Disability Guidelines (ODG) state that spinal fusion is not recommended for patients 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 patient presents with clinical exam and imaging evidence consistent with suspected nerve root compression at L4 and L5. There is evidence of a recent comprehensive non-operative treatment protocol trial and failure. However, there is no imaging evidence of spinal segmental instability, fusion failure, or cord compression. Records document a past medical history of urinary problems, with no current documentation of bowel or bladder complaints. A psychosocial evaluation is not evidenced. Therefore, this request is not medically necessary at this time.

L3-L4 TLIF: Upheld

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): 307. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Lumbar & Thoracic: Fusion (spinal).

Decision rationale: The California MTUS guidelines indicate that lumbar spinal fusion may be considered for patients with increased spinal instability after surgical decompression at the level of degenerative spondylolisthesis. Guidelines state there was no good evidence that spinal fusion alone was effective for treating any type of acute low back problem, in the absence of spinal fracture, dislocation, or spondylolisthesis if there was instability and motion in the segment operated on. The guidelines recommend that clinicians consider referral for psychological screening to improve surgical outcomes. The Official Disability Guidelines (ODG) state that spinal fusion is not recommended for patients 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 patient presents with clinical exam and imaging evidence consistent with suspected nerve root compression at L4 and L5. There is evidence of a recent comprehensive non-operative treatment protocol trial and failure. However, there is no imaging evidence of spinal segmental instability, fusion failure, or cord compression. Records document a past medical history of urinary problems, with no current documentation of bowel or bladder complaints. A psychosocial evaluation is not evidenced. Therefore, this request is not medically necessary at this time.

L4-S1 remove and explore: Upheld

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): 307. Decision based on Non-MTUS Citation Low Back Lumbar & Thoracic: Fusion (spinal).

Decision rationale: The California MTUS guidelines indicate that lumbar spinal fusion may be considered for patients with increased spinal instability after surgical decompression at the level of degenerative spondylolisthesis. Guidelines state there was no good evidence that spinal fusion alone was effective for treating any type of acute low back problem, in the absence of spinal fracture, dislocation, or spondylolisthesis if there was instability and motion in the segment operated on. The guidelines recommend that clinicians consider referral for psychological screening to improve surgical outcomes. The Official Disability Guidelines (ODG) state that spinal fusion is not recommended for patients 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 patient presents with clinical exam and imaging evidence consistent with suspected nerve root compression at L4 and L5. There is evidence of a recent comprehensive non-operative treatment protocol trial and failure. However, there is no imaging evidence of spinal segmental instability, fusion failure, or cord compression. Records document a past medical history of urinary problems, with no current documentation of bowel or bladder complaints. A psychosocial evaluation is not evidenced. Therefore, this request is not medically necessary at this time.