

<b>Case Number:</b>	CM15-0106067		
<b>Date Assigned:</b>	06/10/2015	<b>Date of Injury:</b>	03/31/1999
<b>Decision Date:</b>	07/23/2015	<b>UR Denial Date:</b>	05/22/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/02/2015

### 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: New York

Certification(s)/Specialty: Neurological 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 58-year-old male who sustained an industrial injury on 03/31/1999. Treatment provided to date has included physical therapy, lumbar spine surgery, medications, and conservative therapies/care. Diagnostic tests performed include electro diagnostic and nerve conduction testing of the bilateral upper extremities (01/19/2015); MRI of the cervical spine (07/01/2013) showing multilevel disc bulging; and MRI of the lumbar spine showing lumbar disc disease and previous fusion as well as lumbar spinal stenosis. There were no noted previous injuries or dates of injury, and no noted comorbidities. On 03/17/2015, physician progress report noted complaints of ongoing pain to the low back and neck. The injured worker described the neck and low back pain as burning pain with a severity rating of 10/10. Additional complaints include burning hand and foot pain with a severity rating of 8/10, fatigue, trouble sleeping, hair and nail changes, headaches, ringing in the ears, vision loss/changes, generalized pain and stiffness, heartburn, constipation, diarrhea, changes in appetite, nausea, erectile dysfunction, calf pain with walking, numbness, stress and depression. The physical exam revealed an antalgic gait, mid-line tenderness spasm and tightness to palpation of the cervical spine musculature, restricted/reduced range of motion (ROM) in the cervical spine, mildly positive compression test, positive Spurling's maneuver bilaterally, painful overhead reaching with referral to the suprascapular area, decreased grip strength, decreased median nerve sensation with diffuse radial and median nerve sensitivity, spasm on extension of the lumbar spine, decreased range of motion, pain and weakness with heel-to-toe walk, sciatic stretch, and decreased L5 dermatome sensation. The provider noted diagnoses of chronic headaches, cervical spine discopathy, lumbar spine

disease and bulging, status post lumbar fusion, status post lumbar hardware removal, left wrist injury secondary to low back, left knee strain/sprain, and lumbar spinal stenosis with bilateral foraminal narrowing. Due to increasing pain, the injured worker agrees to the plan for surgical intervention. Plan of care includes an epidural steroid injection to the cervical spine, a L3-4 decompression central canal and bilateral foraminotomy with a date of service, 2 day inpatient stay, pre-operative clearance, one time psychological clearance for surgical intervention, home help (duration and frequency determined post-operatively), post-operative evaluation by a registered nurse, post-op physical therapy for the lumbar spine, post-op lumbar corset, post-op orthopedic bed and mattress, and post-op Zofran. Requested treatments include retrospective request for: L3-4 decompression central canal and bilateral foraminotomy with a date of service (authorized), 2 day inpatient stay (modified), one time psychological clearance for surgical intervention, home help (duration and frequency determined post-operatively), post-operative evaluation by a registered nurse, post-op physical therapy for the lumbar spine, post-op lumbar corset, post-op orthopedic bed and mattress, and post-op Zofran.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

#### **Retrospective Post-Operative Physical Therapy for the Lumbar Spine: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Postsurgical Treatment Guidelines.

**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-Physical Therapy.

**Decision rationale:** The ODG guidelines do recommend post-operative physical therapy. The guidelines recommend specific time for initiation and length of services as well as the intensity of services. Documentation does not include time of onset, frequency or duration. The requested Treatment: Retrospective Post-Operative Physical Therapy for the Lumbar Spine is NOT medically necessary and appropriate.

#### **Retrospective Inpatient Stay (2-days): Overturned**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Low Back Chapter, Hospital Length of Stay (LOS) Guidelines.

**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, and Hospital length of stay.

**Decision rationale:** ODG guidelines recommend a best practice target for a decompressive laminectomy to be a hospitalization of one day. However, the guidelines note the evidence shows a mean hospital length of stay to be 2 days and the median to be 3.5 days. The requested service is medically necessary and appropriate.

**Retrospective One Time Psychological Clearance for Surgical Intervention: Overturned**

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-307.

**Decision rationale:** The California MTUS guidelines do recommend referral for psychological screening if surgery is a consideration. Documentation suggests this would be beneficial as the patient repeatedly describes pain at high levels yet at the time of visit does not seem to display behavior consistent with an organic pain problem. The requested treatment: Retrospective One Time Psychological Clearance for Surgical Intervention is medically necessary and appropriate.

**Retrospective Post-Operative Home Help (duration and frequency determined postoperatively): Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Home Health Services.

**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-home health services.

**Decision rationale:** The ODG guidelines do recommend home health services for recommended medical treatment if the patient is homebound. Documentation is not furnished to support the patient is home bound. Documentation is not provided to support the patient have medical problems that need home health services. The requested treatment: Retrospective Post-Operative Home Help (duration and frequency determined postoperatively) is NOT medically necessary and appropriate.

**Retrospective Post-Operative Evaluation by an RN: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Home Health Services.

**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-home health services.

**Decision rationale:** The ODG guidelines do recommend home health services for recommended medical treatment if the patient is homebound. Documentation is not furnished to support the patient is home bound. Documentation is not provided to support the patient have medical problems that need a RN's evaluation services. The requested treatment: Retrospective Post-Operative Home evaluation by an RN is NOT medically necessary and appropriate.

**Retrospective Post-Operative Lumbar Corset: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

**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-Lumbar supports.

**Decision rationale:** The ODG guidelines note that the use of postoperative lumbar supports is under study. The guidelines specifically do not recommend a support for prevention. When the back brace has been used in patients who have undergone fusion, they point out the immobilization might actually be harmful. Documentation does not contain rationale for the request. The requested treatment: Retrospective Post-Operative Lumbar Corset is NOT medically necessary and appropriate.

**Retrospective Post-Operative Orthopedic Bed and Mattress: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Low Back Chapter, Mattress Selection.

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

**Decision rationale:** The ODG guidelines furnish criteria under which the use of an orthopedic bed and mattress fall. Documentation does not list the evidence, which complies with these criteria. The requested treatment: Retrospective Post-Operative Orthopedic Bed and Mattress is NOT medically necessary and appropriate.

**Retrospective Post-Operative Zofran 8mg, #10: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Pain Chapter, Antiemetics (for opioid nausea).

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Medications Chapter Antiemetics.

**Decision rationale:** The ODG guidelines do recommend Ondansetron (Zofran) for nausea and vomiting secondary to chemotherapy and radiation treatments. Documentation does not show the patient is receiving these treatments. The guidelines do not recommend antiemetic for nausea and vomiting secondary to chronic opioid use. The requested treatment: Retrospective Post-Operative Zofran 8mg, #10 is NOT medically necessary and appropriate.

