

Case Number:	CM15-0146437		
Date Assigned:	08/11/2015	Date of Injury:	01/31/2011
Decision Date:	09/18/2015	UR Denial Date:	07/23/2015
Priority:	Standard	Application Received:	07/28/2015

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:

This injured worker is a 40-year-old female who sustained an industrial injury on 1/31/11. Injury occurred while she was helping someone get off the floor. Conservative treatment included medications, activity modification, physical therapy, right L3 and L4 radiofrequency ablation, and chiropractic treatment. The 6/11/15 lumbar spine MRI impression documented a broad-based disc herniation at L4/5 abutting the thecal sac and producing spinal canal narrowing and bilateral neuroforaminal narrowing. At L5/S1, there was a left paracentral disc herniation abutting the left L5 and S1 nerve roots and producing spinal canal, left lateral recess and neuroforaminal narrowing. There was an impingement of the left L5 exiting nerve root and a posterior annular tear/fissure. The 6/19/15 treating physician report cited persistent pain and stiffness to the lumbar spine radiating up her back and down into both legs, numbness and tingling to the feet. She had been on a week of bed rest due to increasing pain in her low back and legs. Physical exam documented erect stance with normal gait. There was loss of normal lordosis, paraspinal tenderness and spasms, and limited range of motion. Straight leg raise tests were positive bilaterally. Motor testing documented 4+/5 right and 4/5 left iliopsoas, quadriceps, and hamstring weakness, 5-/5 right and 4+/5 left gastrocnemius weakness, and 5/5 right and 5-/5 left extensor hallucis longus and tibialis anterior weakness. There was decreased sensation in the left L5 and S1 nerve distribution. There were trace patellar and Achilles reflexes bilaterally. Imaging demonstrated significant bilateral L4/5 and L5/S1 disc herniations with annular tear at L5/S1, high-grade compression of the right S1 nerve, and moderate discogenic changes. The injured worker remained symptomatic in her lumbar spine despite conservative treatment.

Authorization was requested L4/5 and L5/S1 microdiscectomy, laminar foraminotomy and interlaminar, placement of Coflex motion preservation stabilization device on L5/S1; 2-3 day hospital stay; post-op physical therapy 18-24 visits, home health care for 2-3 weeks, and bone stimulator. The home health care was needed to assist the injured worker with wound checking and redressing, as well as help her with personal hygiene, light cooking and housework, and getting her to and from appointments and doctor's visits. The 7/23/15 utilization review modified the request for L4/5 and L5/S1 microdiscectomy, laminar foraminotomy and interlaminar, placement of Coflex motion preservation stabilization device on L5/S1 and certified the L4/5 and L5/S1 microdiscectomy, laminar foraminotomy. The request for placement of Coflex motion preservation stabilization device on L5/S1 was non-certified as the Official Disability Guidelines did not recommend use of an interspinous decompression device. The request for 2 to 3 day inpatient stay was modified to 2-day stay consistent with the Official Disability Guidelines. The request for 18-24 post-op physical therapy visits was modified to 10 visits as the guidelines only supported up to 16 visits and generally recommend one-half the general course for initial treatment. The request for home health care for 2 to 3 weeks was non-certified as there was no indication that the patient would be homebound for 2 weeks after surgery and rationale for home health care was not provided. The request for bone stimulator was non-certified as there was no indicated that the injured worker was undergoing fusion to support the medical necessity of this request.

IMR ISSUES, DECISIONS AND RATIONALES

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

L4-L5 and L5-S1 Microdiscectmy, Laminar Foraminotomy and Interlaminar, Placement of Coflex motion preservation stabilization device on L5-S1: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 301.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-307. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back & Lumbar & Thoracic: Discectomy/Laminectomy; Interspinous decompression device (X-Stop®).

Decision rationale: The California MTUS recommend surgical consideration when there is severe and disabling lower leg symptoms in a distribution consistent with abnormalities on imaging studies (radiculopathy), preferably with accompanying objective signs of neural compromise. Guidelines require clear clinical, imaging and electrophysiologic evidence of a lesion that has been shown to benefit both in the short term and long term from surgical repair. The guidelines recommend that clinicians consider referral for psychological screening to improve surgical outcomes. The Official Disability Guidelines (ODG) recommends criteria for lumbar discectomy that include symptoms/findings that confirm the presence of radiculopathy and correlate with clinical exam and imaging findings. Guideline criteria include evidence of nerve root compression, imaging findings of nerve root compression, lateral disc rupture, or lateral recess stenosis, and completion of comprehensive conservative treatment. The ODG do not recommend the use of interspinous decompression devices over decompression surgery.

Based on FDA approved indications, interspinous decompression devices are indicated for patients aged 50 or older who are suffering from neurogenic intermittent claudication secondary to a confirmed diagnosis of lumbar spinal stenosis, who would otherwise be candidates for laminectomy. Guideline criteria have been met for the totality of this request. The 7/23/15 utilization review modified this request and approved L4/5 and L5/S1 microdiscectomy and laminar foraminotomy. There is no compelling rationale in the submitted records to support the use of the Coflex interspinous decompression device over decompression surgery for this 40-year-old patient as an exception to guidelines. Therefore, this request is not medically necessary.

Hospital 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 ODG, Hospital Length of stay (LOS).

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: The California MTUS does not provide hospital length of stay recommendations. The Official Disability Guidelines recommend the median length of stay (LOS) based on type of surgery, or best practice target LOS for cases with no complications. The recommended median length of stay for lumbar discectomy is 1 day and best practice target is outpatient. The recommended median length of stay for lumbar laminectomy is 2 days and best practice target is 1 day. The 7/23/15 utilization review modified this request for 2 to 3 days to a 2-day length of stay. There is no compelling rationale presented to support the medical necessity of a 3-day length of stay for this injured worker for the approved decompression procedure. Therefore, this request is not medically necessary.

Post operative Physical Therapy 18-24 visit: Upheld

Claims Administrator guideline: Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 26.

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 26.

Decision rationale: The California Post-Surgical Treatment Guidelines for lumbar discectomy/laminectomy suggest a general course of 16 post-operative physical medicine visits over 8 weeks, during the 6-month post-surgical treatment period. An initial course of therapy would be supported for one-half the general course or 8 visits. With documentation of functional improvement, a subsequent course of therapy shall be prescribed within the parameters of the general course of therapy applicable to the specific surgery. If it is determined that additional functional improvement can be accomplished after completion of the general course of therapy, physical medicine treatment may be continued up to the end of the postsurgical period. The request for 18 to 24 visits exceeds guideline recommendations for the initial and general course of post-op care. The 7/23/15 utilization review modified this request for 18-24 post-op physical therapy visits to 10 visits. There is no compelling rationale to support

the medical necessity of additional certification at this time. Therefore, this request is not medically necessary.

Home Health care for 2-3 weeks: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Home Health Services Page(s): 51.

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

Decision rationale: The California MTUS recommends home health services only for otherwise recommended treatment for patients who are homebound, on a part time or intermittent basis. Medical treatment does not include homemaker services like shopping, cleaning, and laundry, and personal care given by home health aides like bathing, dressing, and using the bathroom when this is the only care needed. Medicare provides specific patient selection criteria for in home services, including the individual is confined to the home and the service must be prescribed and periodically reviewed by the attending physician. Additionally, the individual must be in need of skilled nursing care on an intermittent basis, or physical therapy or speech-language pathology; or have a continuing need for occupational therapy. Guideline criteria have not been met. There is no evidence that the injured worker will be homebound for 2 to 3 weeks. There is no evidence or physician recommendations evidencing the need for intermittent skilled nursing care or physical therapy in the home environment. Additionally, this request does not specify the type and amount of home health care being requested. Therefore, this request is not medically necessary.

Related surgical services; Bone stimulator: Upheld

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

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: The California MTUS guidelines are silent regarding bone growth stimulators. The Official Disability Guidelines indicate that bone growth stimulators are under study and may be considered medically necessary as an adjunct to lumbar spinal fusion surgery for patients with any of the following risk factors for failed fusion: 1) One or more previous failed spinal fusion(s); (2) Grade III or worse spondylolisthesis; (3) Fusion to be performed at more than one level; (4) Current smoking habit; (5) Diabetes, Renal disease, Alcoholism; or (6) Significant osteoporosis which has been demonstrated on radiographs. Guideline criteria have not been met. This injured worker is certified for a lumbar decompression surgery at 2 levels and not a lumbar fusion. There was no compelling rationale to support the medical necessity of a bone growth stimulator in the absence of a spinal fusion. Therefore, this request is not medically necessary.

