MAXIMUS Federal Services

Case Number:	CM15-0148770		
Date Assigned:	08/13/2015	Date of Injury:	09/03/2014
Decision Date:	09/29/2015	UR Denial Date:	07/13/2015
Priority:	Standard	Application Received:	07/31/2015

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: California
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 58 year old male who sustained an industrial injury on 09-03-2014. Current diagnoses include degenerative disc disease and spinal stenosis. Previous treatments included medications, heat and ice, chiropractic, acupuncture, physical therapy, home exercise program, and epidural steroid injection on 02-13-2015. Previous diagnostic studies included a lumbar spine MRI dated 11-26-2014 and lumbar spine x-rays dated 09-22-2014. Report dated 06-10-2015 noted that the injured worker presented with complaints that included low back pain, left leg pain and right leg pain. Left leg pain is associated with numbness and tingling radiating down the back of the leg to the heel and lateral portion of the leg to the foot. Right-sided numbness and tingling and back pain which feels like a band-like distribution across the lower back. Pain level was 5 up to 8 out of 10 on a visual analog scale (VAS). Physical examination of the back was positive for mild back pain with extremes of range of motion, increased pain on extension and increased pain on extreme flexions. Physical examination of the left lower extremity revealed decreased strength in the hip. Physical examination of the right lower extremity did not reveal any abnormalities. The treatment plan included recommendation for L4- S1 anterior spinal fusion, L3-L5 microdecompression, L4-S1 posterior spinal fusion and associated surgical services. Disputed treatments include L4-S1 anterior spinal fusion, L3-L5 microdecompression, L4-S1 posterior spinal fusion, inpatient hospital stay x 2 days, assistant surgeon, vascular surgeon for anterior incision, post-op physical therapy 2 x 6 for the lumbar spine, post-op lumbar brace, post-op Norco 5/325mg #65 x 2 refills, post-op Flexeril 5mg #60 x 2 refills.

IMR ISSUES, DECISIONS AND RATIONALES

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

L4-S1 Anterior spinal fusion, L3-L5 microdecompression, L4-S1 posterior spinal fusion: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 307, 310, 305.

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 ACOEM Guidelines Chapter 12 Low Back Complaints page 307 state that lumbar fusion, "Except for cases of trauma-related spinal fracture or dislocation, fusion of the spine is not usually considered during the first three months of symptoms. Patients with increased spinal instability (not work-related) after surgical decompression at the level of degenerative spondylolisthesis may be candidates for fusion." According to the ODG, Low back, Fusion (spinal) should be considered for 6 months of symptom. Indications for fusion include neural arch defect, segmental instability with movement of more than 4.5 mm, revision surgery where functional gains are anticipated, infection, tumor, deformity and after a third disc herniation. In addition, ODG states, there is a lack of support for fusion for mechanical low back pain for subjects with failure to participate effectively in active rehab pre-op, total disability over 6 months, active psych diagnosis, and narcotic dependence. In this particular patient, there is evidence of medical necessity for lumbar fusion as there is evidence of potential iatrogenic segmental instability following decompression secondary to moderate to severe stenosis at L4-S1 levels. The patient has failed nonsurgical management and there is no evidence to suggest a need for psychiatric clearance. Therefore, the request for lumbar fusion is medically necessary and the determination is for certification.

Associated surgical service: Inpatient hospital stay x 2 days: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability 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, Hospital length of stay.

Decision rationale: CA MTUS/ACOEM is silent on the issue of hospital length of stay following a lumbar fusion. According to the ODG, Low back section, Hospital length of stay, a 3-day inpatient stay is recommended following an anterior lumbar fusion. As a request is for 2 days, the determination is for certification as medically necessary and appropriate.

Associated surgical service: Assistant surgeon: Overturned

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation http://www.aaos.org/about/papers/position/1120.asp.

Decision rationale: CA MTUS/ACOEM/ODG are silent on the issue of assistant surgeon. According to the American College of Surgeons: "The first assistant to the surgeon during a surgical operation should be a trained individual capable of participating and actively assisting the surgeon to establish a good working team. The first assistant provides aid in exposure, hemostasis, and other technical function, which will help the surgeon carry out a safe operation and optimal results for the patient. The role will vary considerably with the surgical operation, specialty area, and type of hospital." There is an indication for an assistant surgeon for the requested lumbar fusion. The guidelines state that "the more complex or risky the operation, the more highly trained the first assistant should be." In this case, the decision for an assistant surgeon is medically necessary and is therefore certified.

Associated surgical service: Vascular surgeon for anterior incision: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 5 Cornerstones of Disability Prevention and Management Page(s): 92.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Office visits.

Decision rationale: CA MTUS/ACOEM is silent on office visits. According to the ODG Pain section, Office visits, Recommended as determined to be medically necessary. Evaluation and management (E&M) outpatient visits to the offices of medical doctor(s) play a critical role in the proper diagnosis and return to function of an injured worker, and they should be encouraged. The need for a clinical office visit with a health care provider is individualized based upon a review of the patient concerns, signs and symptoms, clinical stability, and reasonable physician judgment. The determination is also based on what medications the patient is taking, since some medicines such as opiates, or medicines such as certain antibiotics, require close monitoring. As patient conditions are extremely varied, a set number of office visits per condition cannot be reasonably established. The determination of necessity for an office visit requires individualized case review and assessment, being ever mindful that the best patient outcomes are achieved with eventual patient independence from the health care system through self care as soon as clinically feasible. In this case, the patient is to undergo an anterior lumbar fusion. This meets complexity to warrant a specialist referral such as a vascular surgeon. Therefore, the request is medically necessary and the determination is for certification.

Post-op physical therapy 2 x 6 for the lumbar spine: Overturned

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

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 25-26.

Decision rationale: According to the CA MTUS/Post Surgical Treatment Guidelines, Low Back, Post surgical (fusion) pages 25 and 26, 34 visits are recommended over a 16-week period with post-surgical physical medicine period over 6 month. In this case, the request is below the 1/2 initially allowed and therefore is medically necessary and meets criteria for certification.

Post-op lumbar brace: Overturned

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.

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

Decision rationale: CA MTUS/ACOEM guidelines, Chapter 12, page 301 states, "lumbar supports have not been shown to have any lasting benefit beyond the acute phase of symptom relief." The patient is to undergo a circumferential fusion and therefore the recommended guidelines have been met. The request is medically necessary and the determination is for certification.

Post-op Norco 5/325mg #65 x 2 refills: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 76-78.

Decision rationale: CA MTUS, Chronic Pain Treatment guidelines, under criteria for use of opioids page 76-78 states, states use of opioids should be part of a treatment plan that is tailored to the patient. MTUS pgs 60, 61 goes on to state "Relief of pain with the use of medications is generally temporary, and measures of the lasting benefit from this modality should include evaluating the effect of pain relief in relationship to improvements in function and increased activity." In this, the request for Norco as a postoperative medication is medically necessary and recommended.

Post-op Flexeril 5mg #60 x 2 refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants for pain.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Cyclobenzaprine Page(s): 41-42.

Decision rationale: According to the CA MTUS, Chronic Pain Medical Treatment Guidelines, Cyclobenzaprine, pages 41-42 "Recommended as an option, using a short course of therapy. Cyclobenzaprine (Flexeril) is more effective than placebo in the management of back pain; the effect is modest and comes at the price of greater adverse effects. The effect is greatest in the first 4 days of treatment, suggesting that shorter courses may be better. (Browning, 2001) Treatment should be brief. There is also a post-op use. The addition of Cyclobenzaprine to other agents is not recommended." In this particular case, the patient has no evidence to anticipate a need postoperatively following lumbar fusion. Therefore, the request is not medically necessary and non-certified.