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| Case Number: | CM15-0187673 | | |
| Date Assigned: | 10/21/2015 | Date of Injury: | 01/25/2000 |
| Decision Date: | 12/07/2015 | UR Denial Date: | 09/14/2015 |
| Priority: | Standard | Application Received: | 09/23/2015 |

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: Anesthesiology

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 52 year old male, who sustained an industrial injury on 1-25-2000. The injured worker is diagnosed with lumbago, left lumbar radiculopathy and chronic pain syndrome and post lumbar laminectomy with post laminectomy syndrome. His disability status is permanent and stationary. Notes dated 8-20-15 and 9-9-15 reveals the injured worker presented with complaints of severe back pain as well as left leg pain associated with numbness to his foot. His pain is rated at 8-9 out of 10. He reports his activities of daily living are affected due to the debilitating and severe pain. Physical examinations dated 6-29-15, 8-20-15 and 9-9-15 revealed moderate to severe tenderness to palpation over the: L4-L5 and L5-S1 lumbar interspaces and muscular guarding over the bilateral erector spinae muscles" and left buttock region. The lumbar spine range of motion is decreased with guarding noted and the straight leg raise is positive on the left. Treatment to date has included lumbar laminectomy, medications, which reduce his pain by 50-60% per note dated 9-9-15 and physical therapy and injections were not beneficial per note dated 8-20-15. Diagnostic studies include lumbar spine MRI and x-rays. A request for authorization dated 9-4-15 for anterior lumbar interbody fusion at L2-L5 with open reduction followed by an anterolateral interbody fusion at L1-L2 and associated services is non-certified, per Utilization Review letter dated 9-11-15.

IMR ISSUES, DECISIONS AND RATIONALES

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

Anterior Lumbar Interbody Fusion at L2-L5 with Open Reduction followed by an Anterolateral Interbody Fusion at L1-L2: Upheld

Claims Administrator guideline: Decision based on MTUS Low Back Complaints 2004.

MAXIMUS guideline: Decision based on MTUS Low Back Complaints 2004, Section(s): Surgical Considerations. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Fusion (spinal).

Decision rationale: According to the MTUS/ACOEM guidelines, patients with increased spinal instability (not work-related) after surgical decompression at the level of degenerative spondylolisthesis may be candidates for fusion. There is no good evidence from controlled trials that spinal fusion alone is effective for treating any type of acute low back problem, in the absence of spinal fracture, dislocation, or spondylolisthesis if there is instability and motion in the segment operated on. According to the ODG, a lumbar spinal fusion is recommended as an option for the following conditions with ongoing symptoms, corroborating physical findings and imaging, and after failure of non-operative treatment (unless contraindicated e.g. acute traumatic unstable fracture, dislocation, spinal cord injury) subject to these criteria: (1) Spondylolisthesis (isthmic or degenerative) with at least one of these: (a) instability, and/or (b) symptomatic radiculopathy, and/or (c) symptomatic spinal stenosis; (2) Disc herniation with symptomatic radiculopathy undergoing a third decompression at the same level; (3) Revision of pseudoarthrosis (single revision attempt); (4) Unstable fracture; (5) Dislocation; (6) Acute spinal cord injury (SCI) with post-traumatic instability; (7) Spinal infections with resultant instability; (8) Scoliosis with progressive pain, cardiopulmonary or neurologic symptoms, and structural deformity; (9) Scheuermann's kyphosis; (10) Tumors. Pre-operative clinical surgical indications for spinal fusion should include all of the following: (1) All physical medicine and manual therapy interventions are completed with documentation of reasonable patient participation with rehabilitation efforts including skilled therapy visits, and performance of home exercise program during and after formal therapy. Physical medicine and manual therapy interventions should include cognitive behavioral advice (e.g. ordinary activities are not harmful to the back, patients should remain active, etc.); (2) X-rays demonstrating spinal instability and/or myelogram, CT-myelogram, or MRI demonstrating nerve root impingement correlated with symptoms and exam findings; (3) Spine fusion to be performed at one or two levels; (4) Psychosocial screen with confounding issues addressed; the evaluating mental health professional should document the presence and/or absence of identified psychological barriers that are known to preclude post-operative recovery; (5) For any potential fusion surgery, it is recommended that the injured worker refrain from smoking for at least six weeks prior to surgery and during the period of fusion healing; (6) There should be documentation that the surgeon has discussed potential alternatives, benefits and risks of fusion with the patient; (7) For average hospital LOS after criteria are met, guidelines should be followed. In this case, there is no documentation of nerve impingement or lumbar spine instability. The medical records document a negative straight leg raise with flexion at 10 degrees and extension at 5 degrees. There were no signs or symptoms of spinal cord compression or cauda equina syndrome. In addition, the physician stated that a psychosocial screening had not been performed. Medical necessity of the requested anterior

lumbar interbody fusion (ALIF) at L2-L5 with open reduction followed by an ALIF at L1-L2 has not been established. The requested surgical procedures are not medically necessary.

Posterior Spinal Fusion (PSF)/I at T10-L5: Upheld

Claims Administrator guideline: Decision based on MTUS Low Back Complaints 2004.

MAXIMUS guideline: Decision based on MTUS Low Back Complaints 2004, Section(s): Surgical Considerations. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Fusion (spinal).

Decision rationale: According to the MTUS/ACOEM guidelines, patients with increased spinal instability (not work-related) after surgical decompression at the level of degenerative spondylolisthesis may be candidates for fusion. There is no good evidence from controlled trials that spinal fusion alone is effective for treating any type of acute low back problem, in the absence of spinal fracture, dislocation, or spondylolisthesis if there is instability and motion in the segment operated on. According to the ODG, a lumbar spinal fusion is recommended as an option for the following conditions with ongoing symptoms, corroborating physical findings and imaging, and after failure of non-operative treatment (unless contraindicated e.g. acute traumatic unstable fracture, dislocation, spinal cord injury) subject to these criteria: (1) Spondylolisthesis (isthmic or degenerative) with at least one of these: (a) instability, and/or (b) symptomatic radiculopathy, and/or (c) symptomatic spinal stenosis; (2) Disc herniation with symptomatic radiculopathy undergoing a third decompression at the same level; (3) Revision of pseudoarthrosis (single revision attempt); (4) Unstable fracture; (5) Dislocation; (6) Acute spinal cord injury (SCI) with post-traumatic instability; (7) Spinal infections with resultant instability; (8) Scoliosis with progressive pain, cardiopulmonary or neurologic symptoms, and structural deformity; (9) Scheuermann's kyphosis; (10) Tumors. Pre-operative clinical surgical indications for spinal fusion should include all of the following: (1) All physical medicine and manual therapy interventions are completed with documentation of reasonable patient participation with rehabilitation efforts including skilled therapy visits, and performance of home exercise program during and after formal therapy. Physical medicine and manual therapy interventions should include cognitive behavioral advice (e.g. ordinary activities are not harmful to the back, patients should remain active, etc.); (2) X-rays demonstrating spinal instability and/or myelogram, CT-myelogram, or MRI demonstrating nerve root impingement correlated with symptoms and exam findings; (3) Spine fusion to be performed at one or two levels; (4) Psychosocial screen with confounding issues addressed; the evaluating mental health professional should document the presence and/or absence of identified psychological barriers that are known to preclude post-operative recovery; (5) For any potential fusion surgery, it is recommended that the injured worker refrain from smoking for at least six weeks prior to surgery and during the period of fusion healing; (6) There should be documentation that the surgeon has discussed potential alternatives, benefits and risks of fusion with the patient; (7) For average hospital LOS after criteria are met, guidelines should be followed. In this case, there is no documentation of nerve impingement or lumbar spine instability. The medical records document a negative straight leg raise with flexion at 10 degrees and extension at 5 degrees. There were no signs or symptoms of spinal cord compression or cauda equina syndrome. In addition, the physician stated that a psychosocial screening had not been performed. Medical necessity of the requested posterior

spinal fusion at T10-L5 has not been established. The requested surgical procedures are not medically necessary.

Associated Surgical Service: Hospital Stay (4-days): Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

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

Associated Surgical Service: Surgical Assistant: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

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

Associated Surgical Service: Consultation with Co Surgeon: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

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

Associated Surgical Service: Medical Clearance Appointment: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

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

Pre-Operative Work-up: CBC: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

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

Pre-Operative Work-up: CMP: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

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

Pre-Operative Work-up: PT/PTT, INR: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

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

Pre-Operative Work-up: UA: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

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

Pre-Operative Work-up: EKG: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

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

Pre-Operative Work-up: Chest X-Ray: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

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

Post-Operative Home Health RN (8-visits): Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

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

Associated Surgical Service: Home Health Physical Therapy (8-visits): Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

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

Associated Surgical Service: Lumbar Back Brace: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

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

Associated Surgical Service: Front Wheeled Walker: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

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

Associated Surgical Service: 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 cite any medical evidence for its decision.

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