

Case Number:	CM15-0030028		
Date Assigned:	02/23/2015	Date of Injury:	09/09/2011
Decision Date:	05/01/2015	UR Denial Date:	01/23/2015
Priority:	Standard	Application Received:	02/18/2015

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: Pediatrics, 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 73-year-old male who reported an injury on 09/09/2011, there was no mechanism of injury provided. The injured worker's diagnoses include low back pain with degenerative disc disease, spondylolisthesis and severe stenosis at L4-5 with right leg radiculopathy. The injured worker has previously had physical therapy and epidural injections. The injured worker complains of low back pain that radiates into his right thigh and leg. He rates his lumbar spine pain 7/10, and states that it is worsening. He also notes that the pain is made better with rest and medication. The physical exam notes that the injured worker had a positive straight leg raise on the right at 45 degrees, and negative straight leg raise on the left. He had 4/5 strength in the right extensor hallucis longus, and 5/5 strength in left extensor hallucis longus, 5/5 strength in bilateral hip flexion, quads, tibialis anterior, and gastroc. There was diffuse paraspinal tenderness. The range of motion was limited to 30 degrees of flexion and 20 degrees of extension. There was also intact sensation and a positive Kemp's sign. There were no medications provided. Documentation notes that the injured worker has already had extensive conservative treatment with therapy and pain management. The pain has gotten worse despite epidural injections and therapy. The treatment plan is for a L4-5 transforaminal and posterior fusion and L4-5 laminectomy.

IMR ISSUES, DECISIONS AND RATIONALES

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

Inpatient L4-5 Transforaminal & Posterior Fusion & L4-5 Laminectomy: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Page(s): 305-306. Decision based on Non-MTUS Citation Official Disability Guidelines.

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 (spinal).

Decision rationale: The California Medical Treatment Guidelines/ACOEM note that if there is increased spinal instability after surgical decompression at the level of degenerative spondylolisthesis may be candidates for fusion. The Official Disability Guidelines recommend that the injured worker have tried physical therapy and manual therapy interventions as well as identified and treated all pain generators. There needs to be an x-ray demonstrating spinal instability as well as an MRI that demonstrates disc pathology correlated with symptoms and exam findings. There needs to be a psychosocial screen with confounding issues addressed. There is documented decreased strength of 4/5 in the right extensor hallucis longus with 5/5 strength in the left extensor hallucis longus, bilateral hip flexion, quads, tibialis anterior, and gastroc. The injured worker had sensation that was intact throughout with a decreased range of motion. There was no documentation of the injured worker receiving any psychosocial screening. There were also no significant neurologic deficits that were documented on the physical exam. The injured workers spinal instability was at 4 mm and the guidelines recommend that it be more than 4.5 mm. Given the above, the request for inpatient L4-5 transforaminal and posterior fusion and L4-5 laminectomy is not medically appropriate.

Pre-Op Medical Clearance: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Knee, Preoperative testing, general.

Decision rationale: The Official Disability Guidelines recommend preoperative lab testing for patients undergoing surgery. Preoperative urinalysis is recommended for patients undergoing invasive neurologic procedures. Electrolyte and creatinine testing should be performed in patients with underlying chronic disease, and those taking medications that predispose them to electrolyte abnormalities or renal failure. A complete blood count is indicated for patients with diseases that increase the risk of anemia or patients in whom significant perioperative blood loss is anticipated. There was no documentation that the injured worker is undergoing any invasive neurologic procedures. There was also no previous documentation of the injured worker having any chronic disease or taking any medications that would predispose them to electrolyte abnormalities. There was no documentation of any diseases that would increase the injured

worker's risk of anemia or to have any significant perioperative blood loss. There was also no reported history of bleeding or medical conditions that would predispose him to bleeding for a coagulation study to be needed. Given that the request for inpatient L4-5 transforaminal posterior fusion and L4-5 laminectomy is non-certified, the request for preop medical clearance is not medically necessary.

Associated Surgical Service: Polar Care Unit: 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), Knee, Cold/heat packs.

Decision rationale: The injured worker has 7/10 pain that was getting worse and was not being helped by physical therapy, medications, or epidural steroid injections. The injured worker has decreased range of motion with normal strength and intact sensation. The Official Disability Guidelines recommend cold/heat packs/cryotherapy for acute pain. Given that the above request for inpatient L4-5 transforaminal and posterior fusion and L4-5 laminectomy is non-certified, the request for the polar care unit is not medically necessary.

Associated Surgical Service: Walker: 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) Knee, Walking aids.

Decision rationale: The injured worker had 7/10 pain that is getting worse and not helped by epidural steroid injections, medications, or physical therapy. There was decreased range of motion with normal strength and intact sensation. The Official Disability Guidelines note that walkers are indicated for patients with knee or leg pain. Walkers can be used for patients with lower extremity disability, pain, and age related impairments. Given the above request of L4-5 transforaminal and posterior fusion and L4-5 laminectomy was non-certified, the request for a walker is not medically necessary.

Post-Op Physical Therapy 2x6 =12: Upheld

Claims Administrator guideline: Decision based on MTUS Postsurgical Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back chapter.

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

Decision rationale: The injured worker has 7/10 pain that is worsening and is not helped by epidural steroid injections, physical therapy, or medications. The injured worker had decreased range of motion with a positive straight leg raise. There is also 5/5 strength and intact sensation. The California Postsurgical Treatment Guidelines recommend 34 visits over 16 weeks for postsurgical treatment of a spinal fusion. However, given the above request for L4-5 transforaminal and posterior fusion and L4-5 laminectomy was non-certified, the request for post-op physical therapy 2x6 =12 is not medically necessary.