

<b>Case Number:</b>	CM14-0041218		
<b>Date Assigned:</b>	08/01/2014	<b>Date of Injury:</b>	03/22/2001
<b>Decision Date:</b>	09/11/2014	<b>UR Denial Date:</b>	03/17/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/07/2014

### 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. The expert reviewer is Board Certified in Orthopedic Surgery and is licensed to practice in Texas. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### 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 female who reported injury on 03/22/2011. The diagnoses included displacement lumbar intervertebral disc without myelopathy. The documentation indicated the injured worker underwent a fusion at L4-S1. The mechanism of injury was not provided. The documentation of 02/17/2014 revealed the injured worker had complaints of pain. The injured worker was noted to be taking medications including Norco, Prilosec and anti-inflammatories. The objective findings revealed the injured worker had paraspinal tenderness of the lumbar spine along the surgical scar and proximal to the scar. There was decreased range of motion of the lumbosacral spine. The neurologic examination was intact to bilateral lower extremities. The diagnoses included status post posterior spinal fusion L4-5, L5-S1, L3-4 discogenic pain with stenosis and stress and anxiety. The treatment plan included a referral to a pain management specialist and the injured worker was given medications including Relafen and Prilosec, surgical treatment if the form of anterior interbody fusion at L3-4 with posterolateral fusion with instrumentation, an RN evaluation for postoperative home health and wound care, multiple DME, a bone growth stimulator and 12 sessions of postoperative physical therapy, a combo stem electrotherapy, and 12 sessions of postoperative physical therapy.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Pain Management Specialist Consultation:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines Ongoing Management, Page(s): 78.

**Decision rationale:** The California MTUS guidelines recommend consideration of a consultation with a multidisciplinary pain clinic if doses of opioids are required beyond what is usually required for the condition or pain does not improve on opioids in 3 months. The clinical documentation submitted indicated the injured worker had been utilizing opioids. However, there was a lack of documentation indicating the duration of use and the documentation indicated the medications were being managed by a non-pain management specialist. There was no rationale to indicate why the injured worker could not continue to be followed by the non-pain management specialist. Given the above, the request for pain management specialist consultation is not medically necessary.

**Anterior interbody fusion at L3-L4 with possible posterolateral fusion with instrumentation:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back Chapter, Indications for surgery, Fusion.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 307-309.

**Decision rationale:** The California ACOEM Guidelines indicate a surgical consultation may be appropriate for injured workers who have severe and disabling lower leg symptoms in a distribution consistent with abnormalities on imaging studies preferably with accompanying objective signs of neural compromise, activity limitations due to radiating leg pain for more than 1 month or the extreme progression of lower leg symptoms, clear clinical, imaging and electrophysiologic evidence of a lesion that has been shown to benefit in both the short and long term from surgical repair as well as a failure of conservative treatment to resolve disabling radicular symptoms. The ACOEM Guidelines further indicate that there is no good evidence from controlled trials that spinal fusion alone is effective treatment for any type of acute low back problem, in the absence of spinal fracture, dislocation or spondylolisthesis if there is an instability and motion in the segment operated on. The clinical documentation submitted for review failed to meet the above criteria. There was a lack of documentation of imaging evidence as no MRI was presented for review. There was a lack of documentation of instability and motion at the level of L3-4 as there were no radiologic studies included flexion and extension values or MRI findings submitted for review. There was no objective examination revealing lumbar spine instability. Given the above, the request for anterior interbody fusion at L3-L4 with possible posterolateral fusion with instrumentation is not medically necessary.

**Registered Nurse (RN) evaluation for postoperative home health care for the purpose of wound cleaning and assistance with daily living activities:** 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:** As the primary service is not supported, this associated service is also not supported.

**Home health services 8 hours daily for 4 weeks, followed by 4 hours daily for 2 weeks:**  
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:** As the primary service is not supported, this associated service is also not supported.

**Purchase of motorized cold therapy unit:** 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:** As the primary service is not supported, this associated service is also not supported.

**Purchase of combo stimulation unit:** 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:** As the primary service is not supported, this associated service is also not supported.

**Purchase of deep vein thrombosis (DVT) Max:** 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:** As the primary service is not supported, this associated service is also not supported.

**Purchase of front wheel 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:** As the primary service is not supported, this associated service is also not supported.

**Purchase of 3-in-1 commode:** 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:** As the primary service is not supported, this associated service is also not supported.

**Purchase of lumbar sacral orthosis (LSO) 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:** As the primary service is not supported, this associated service is also not supported.

**Purchase of 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:** As the primary service is not supported, this associated service is also not supported.

**12 sessions of postoperative physical therapy:** 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:** As the primary service is not supported, this associated service is also not supported.