

Case Number:	CM14-0210359		
Date Assigned:	12/23/2014	Date of Injury:	11/25/2000
Decision Date:	02/27/2015	UR Denial Date:	11/28/2014
Priority:	Standard	Application Received:	12/16/2014

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. 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: 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:

The injured worker is a 58-year-old male with a reported injury on 11/25/2000. The injury reportedly occurred when the injured worker lost his balance on a concrete stairway, and while trying to gain his balance, his right great toe hyperextended and his right ankle twisted. His diagnoses were noted to include spondylolisthesis. His prior treatments have included medications, activity modification, physical therapy, the use of a cane, occasional rehabilitation, aquatic therapy, and a home exercise program. His diagnostic testing has included multiple x-rays, CTs, and MRIs. The most recent lumbar spine MRI was on 09/26/2014 and reported (1) moderate to marked degenerative joint disease primarily L3-4 through L5-S1; (2) degenerative time grade 1 anterolisthesis of L4 on L5 with no spondyloses; (3) degenerative type central spinal canal narrowing severe at L4-5, moderate at L3-4, and mild at L5-S1 due to disc bulges and facet joint and ligamentum flavum hypertrophy and anterolisthesis at L4-5; (4) moderate sized bilateral neural foraminal disc protrusion and narrowing L3-4 in combination with facet joint arthropathy; (5) left paracentral disc extrusion L4-5 with superior extrusion of the disc fragment as seen on sagittal image 6, series 3; (6) facet joint and ligamentum flavum hypertrophy mild to severe L3-4 to L5-S1 and mild at other levels; (7) no fractures or bony lesions; conus and cauda equina normal. The injured worker's most recent lumbar spine x-ray was an x-ray of the lumbar spine flexion and extension on 12/09/2014 which reported degenerative changes are present; there is stable retrolisthesis at L3-4, and anterolisthesis at L4-5 increases with flexion. His surgical history has included an unspecified right foot surgery in 02/2001, a colon resection in 2006, a left hip arthroplasty revision with irrigation and debridement on 05/02/2009, removal

of antibiotic beads on 05/28/2009, and a right hip arthroplasty in 11/2011. The injured worker was evaluated for back pain on 11/13/2014. He reported that his back pain had progressively increased over time. He described his pain as constant, increased with any type of activity, and as a burning, stabbing sensation in the low back with radiation to the right buttock. He reported his pain would escalate with activities such as walking or standing for any distance, or if he moved in a certain position, he would develop pain radiating down the right leg to his foot, and occasionally into the left leg, as well. He reported his pain prevented him from walking more than a quarter of a mile or sitting for more than half an hour, or standing for more than 10 minutes. His pain prevented him from sleeping for more than 4 hours. He reported he had tried physical therapy and TENS units. He also reported some acupuncture without any improvement. The only thing that seemed to help dull the pain was Norco. Physical examination revealed no costovertebral angle tenderness. No direct tenderness to palpation of the spine. There were moderate bilateral paraspinous muscle spasms with an extremely restricted range of motion. He was only able to flex a few degrees. He was able to extend to neutral. Right and left lateral bending fingertips to proximal thighs. He had fair range of motion of his hips with pain with rotation bilaterally. There was no tenderness to palpation or compression of the pelvis. He was able to stand in fairly overall normal alignment and was able to get onto his heels and toes, but was unable to walk on his heels and toes because of the right foot problem. He walks with an antalgic abductor gait. Deep tendon reflexes were absent in the upper and lower extremities. Motor strength was 5/5. Sensation was intact to light touch. Straight leg raises were negative. The diagnosis was L4-5 spondylolisthesis and stenosis. The patient refused injections, rhizotomies, or any other conservative care. The patient requested surgical intervention. The patient's morbid obesity was discussed, and a request was submitted for an L4-5 decompression, TLIF instrumentation and fusion. The clinician indicated that the patient understood that there was a low likelihood of having the procedure approved. His medications were noted to include tramadol, hydrocodone/acetaminophen, insulin, and etodolac. The request was for L4-5 decompression TLIF instrumentation and fusion, assistant surgeon, 4 day inpatient stay, preoperative electrocardiogram, preoperative chest x-ray, preoperative labs, preoperative urinalysis, preoperative evaluation with surgeon, preoperative evaluation with primary treating physician for medical clearance, and postoperative x-ray of AP/lateral lumbar.

IMR ISSUES, DECISIONS AND RATIONALES

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

L4-L5 Decompression TLIF instrumentation and fusion QTY #1: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)- Indications for surgery

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

Decision rationale: The request for L4-L5 decompression TLIF instrumentation and fusion QTY #1 is not medically necessary. The patient continued to complain of back pain. The California MTUS/ACOEM Guidelines state that there is no scientific evidence about long term

effectiveness of any form of surgical decompression or fusion for degenerative lumbar spondylosis compared with natural history, placebo, or conservative treatment. 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 stability and motion of the segment operated on. It is important to note that although it is being undertaken, lumbar fusion in patients with other types of low back pain very seldom cures the patient. While the injured worker did have documentation of L4-5 spondylolisthesis and stenosis, the treating clinician indicated that facet injections from L3 to the sacrum followed by rhizotomy if the injections were successful would be appropriate treatment. There was no documentation of segmental instability and the provided documentation did not indicate that all pain generators were identified and treated. There was no documentation of a psychosocial screening with confounding issues addressed such as the patient's BMI was 44.7 and he is an insulin dependent diabetic; these conditions should be evaluated in his psychosocial screening prior to a surgical procedure. The most recent x-ray, dated 12/09/2014, indicated degenerative changes were present with stable retrolisthesis at L3-4 and anterolisthesis at L4-5 that increased with flexion. Therefore, the request for L4-L5 decompression TLIF instrumentation and fusion QTY #1 is not medically necessary.

Associated service: Assistant surgeon QTY #1: 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)- Back-Lumbar & Thoracic, Surgical assistant

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 (Acute & Chronic), Surgical assistant.

Decision rationale: The request for associated service: assistant surgeon QTY #1 is not medically necessary. The surgical procedure has not been approved. The Official Disability Guidelines do recommend a surgical assistant as an option in more complex surgeries, such as interbody fusion with instrumentation. However, the requested surgical intervention was not approved. Therefore, the request for associated service: assistant surgeon QTY #1 is not medically necessary.

Associated service: Inpatient stay 4 days: 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)- hospital length of stay. Lumbar fusion, posterior

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 (Acute & Chronic), Hospital length of stay (LOS).

Decision rationale: The request for associated service: inpatient stay 4 days is not medically necessary. The requested lateral lumbar decompression and fusion was not certified. The Official Disability Guidelines recommend a 3 day hospital length of stay for a lateral lumbar fusion. The requested inpatient stay exceeds the guideline recommendations. As the surgical procedure was not approved, the associated service is not supported. Therefore, the request for associated service: inpatient stay 4 days is not medically necessary.

Associated service: Pre-operative Electrocardiogram (EKG) QTY #1: 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)- Back, Lumbar and Thoracic

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 (Acute & Chronic), Preoperative electrocardiogram (ECG).

Decision rationale: The request for associated service: pre-operative electrocardiogram (EKG) QTY #1 is not medically necessary. The requested L4-5 decompression TLIF instrumentation and fusion quantity 1 was non-certified. The Official Disability Guidelines recommend preoperative electrocardiogram for patients undergoing high risk surgery and those undergoing intermediate risk surgery who have additional risk factors. As the patient has additional risk factors of morbid obesity and diabetes, and the surgical procedure would be classified as intermediate risk, the preoperative electrocardiogram would be supported if the surgical intervention were approved. However, the request for L4-5 decompression TLIF instrumentation and fusion was non-certified. As such, the requested preoperative electrocardiogram is not supported. Therefore, the request for associated service: pre-operative electrocardiogram (EKG) QTY #1 is not medically necessary.

Associated service: Pre-operative chest x-ray QTY #1: 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)- Back-Lumbar and Thoracic

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 (Acute & Chronic), Preoperative testing, general.

Decision rationale: The request for associated service: pre-operative chest x-ray qty #1: is not medically necessary. The surgical procedure for L4-5 decompression TLIF instrumentation and fusion was non-certified. The Official Disability Guidelines state that general preoperative testing, such as chest radiography, should be guided by the patient's clinical history, comorbidities, and physical examination findings. As the surgical procedure for L4-5 decompression TLIF instrumentation and fusion was not approved, the preoperative chest x-ray

is not supported. Therefore, the request for associated service: pre-operative chest x-ray qty #1: is not medically necessary.

Associated service: Pre-operative labs: Complete Blood Count (CBC), Inc platelets, Chem 12 Prothrombin, Partial thromboplastin time QTY #1: 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)- Back-Lumbar and Thoracic

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 (Acute & Chronic), Preoperative lab testing.

Decision rationale: The request for associated service: pre-operative labs: complete blood count (CBC), inc platelets, chem 12 prothrombin, partial thromboplastin time QTY #1 is not medically necessary. The associated surgical procedure of L4-5 decompression TLIF instrumentation and fusion quantity #1 was non-certified. The Official Disability Guidelines recommend electrolyte and creatinine testing in patients with underlying chronic disease and those taking medications that predispose them to electrolyte abnormalities or renal failure, a completed blood count for patients with diseases that increase the risk of anemia or patients in whom significant perioperative blood loss is anticipated, and coagulation of studies are reserved for patients with a history of bleeding or medical conditions that predispose them to bleeding, and for those taking anticoagulants. As the associated surgical procedure was non-certified, the preoperative laboratory testing is not supported. Therefore, the request for associated service: pre-operative labs: complete blood count (CBC), inc platelets, chem 12 prothrombin, partial thromboplastin time QTY #1 is not medically necessary.

Associated service: Pre-operative Urinalysis with and without micro QTY #1: 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)- Back-Lumbar and thoracic

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 (Acute & Chronic), Preoperative lab testing.

Decision rationale: The request for associated service: pre-operative urinalysis with and without micro QTY #1 is not medically necessary. The associated surgical procedure of L4-5 decompression TLIF instrumentation and fusion quantity #1 was not approved. The Official Disability Guidelines state that preoperative urinalysis is recommended for patients undergoing invasive urologic procedures and those undergoing implantation of foreign material. Were the associated procedure of TLIF instrumentation and fusion to be approved, the requested service would be supported. However, the associated procedure of L4-5 decompression TLIF

instrumentation and fusion quantity #1 was non-certified. Therefore, the request for associated service: pre-operative urinalysis with and without micro QTY #1 is not medically necessary.

Associated service: Pre-operative evaluation with surgeon QTY #1: 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)-consultations

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-306.

Decision rationale: The request for associated service: pre-operative evaluation with surgeon QTY #1 is not medically necessary. The associated service of L4-5 decompression TLIF instrumentation and fusion quantity #1 was not approved. The California MTUS/ACOEM Guidelines state that if surgery is a consideration, then counseling regarding likely outcomes, risks and benefits, and especially, expectations is very important. As such, had the associated surgical procedure been approved, the requested service would be supported. However, the associated surgical procedure was not approved. Therefore, the requested service is not supported. Therefore, the request for associated service: pre-operative evaluation with surgeon QTY #1 is not medically necessary.

Associated Service: Pre-operative evaluation with PTP for medical clearance QTY #1: 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)-Back-Lumbar and thoracic

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 (Acute & Chronic), Preoperative testing, general.

Decision rationale: The request for associated service: pre-operative evaluation with PTP for medical clearance QTY #1 is non-certified. The associated surgical procedure of L4-5 decompression TLIF instrumentation and fusion was non-certified. The Official Disability Guidelines state that a decision to order to preoperative tests should be guided by the patient's clinical history, comorbidities, and physical examination findings. As such, were the surgical procedure to be approved, this requested ancillary service would be supported. However, the associated surgical procedure was non-certified. Therefore, the request for associated service: pre-operative evaluation with PTP for medical clearance QTY #1 is non-certified.

Associated service: post operative x-ray: AP/ lateral lumbar QTY #1: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints
Page(s): 308-310.

Decision rationale: The request for associated service: post operative x-ray: AP/ lateral lumbar QTY #1 is not medically necessary. The associated surgical procedure was not certified. The California MTUS/ACOEM Guidelines state that MRI is the test of choice for patients with prior back surgery. However, the associated surgical procedure was not certified. Therefore, the request for associated service: post operative x-ray: AP/ lateral lumbar QTY #1 is not medically necessary.