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| Case Number: | CM15-0119689 | | |
| Date Assigned: | 07/23/2015 | Date of Injury: | 07/26/1998 |
| Decision Date: | 09/17/2015 | UR Denial Date: | 06/18/2015 |
| Priority: | Standard | Application Received: | 06/22/2015 |

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 70 year old male, who sustained an industrial injury on 7/26/98. The injured worker was diagnosed as having low back pain, neck pain and long term use of medications. Treatment to date has included cervical fusion, oral medications including Norco, Tramadol, Gabapentin, Dilaudid, Cyclobenzaprine and Ibuprofen; back surgery, acupuncture, and physical therapy. (MRI) magnetic resonance imaging of cervical spine performed on 1/30/15 revealed mild diffuse bulging of C6-7, mild anterolisthesis and central disc bulge of C4-5 without cord compression, diffuse disc bulge of C203, mild to moderate foraminal stenosis C3-5, sold anterior interbody fusion of C5-6 and interosseous cyst within the ventral portion of the neck. Electromyogram performed on 3/10/15 revealed no evidence of lower motor neuro or muscle disease and normal studies of upper extremities and cervical paraspinal muscles. Currently on 6/10/15, the injured worker presents with low back pain with radiation to the left buttock, left posterior thigh and left calf, he describes the pain as constant, moderate, sharp and stabbing and neck pain with radiation to the right shoulder, arms and right hand described as moderate , constant and aching with right upper extremity paresthesia. Physical exam performed on 6/10/15 revealed pain over the bilateral superior medial trapezius with palpation and restricted cervical range of motion; pain is also noted over the bilateral lumbar paraspinal muscles on palpation with restricted lumbar range of motion. Muscle strength in lumbar and cervical spine are noted to be normal and normal sensation of cervical and lumbar areas is also noted. Request for authorization was submitted on 5/19/15 for posterior cervical laminectomy at C6-7 and posterior spinal instrumentation at C6-7, assistant surgeon, internal medicine

clearance, one night inpatient hospitalization for cervical spine surgery, postoperative physical therapy for cervical spine, cervical brace, transportation, lumbar decompression surgery at L3-4, lumbar brace; postoperative physical therapy for the lumbar spine, two nights inpatient hospitalization for lumbar spine surgery, home health evaluation, bed rental and Norco.

IMR ISSUES, DECISIONS AND RATIONALES

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

Posterior cervical laminectomy and posterior spinal instrumentation at C6-7: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 179-181 and 183.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 181-183.

Decision rationale: Per the CA MTUS/ACOEM guidelines, Neck and upper back complaints, pages 181-183 surgery is not recommended for non-radiating pain or in absence of evidence of nerve root compromise. There is no evidence of correlating nerve root compromise from the exam of 6/10/15. The patient has radiating pain from the exam notes but this does not correlate with the cervical spine MRI from 1/30/15. There is lack of severe central canal stenosis from the MRI of 1/30/15 to warrant the multilevel cervical decompression and fusion. Therefore the patient does not meet accepted guidelines for the procedure and the request is not medically necessary.

Associated surgical service: Assistant surgeon: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Centers for Medicare and Medicaid Services.

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

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

Associated surgical service: Medical clearance: 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) Low back, Preoperative testing.

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

Associated surgical service: Inpatient stay x 1 day: Upheld

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) Neck, Hospital length of stay.

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

Post-op physical therapy: Upheld

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

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

Decision rationale: As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.

Associated surgical service: Cervical brace: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 175.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 175.

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

Lumbar decompression at L3-4: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 288 and 305-306.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 308-310. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low back, Discectomy/laminectomy.

Decision rationale: CA MTUS/ACOEM Low back complaints, pages 308-310 recommends surgical consideration for patients with persistent and severe sciatica and clinical evidence of nerve root compromise if symptoms persist after 4-6 weeks of conservative therapy. According to the ODG Low Back, discectomy/laminectomy criteria, discectomy is indicated for correlating distinct nerve root compromise with imaging studies. In this patient there are no notes documenting progressive symptoms or a clear lumbar radiculopathy. Therefore the guideline criteria have not been met and the request is not medically necessary.

Associated surgical service: Lumbar brace: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 298.

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

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

Post-op physical therapy: Upheld

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

Associated surgical service: Inpatient hospital stay x 2 nights: Upheld

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

Associated surgical service: Home health evaluation: Upheld

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) Pain section, Home health services.

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

Associated surgical service: Bed rental: 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 and Leg, DME.

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

Unknown Norco: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 80.

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