

Case Number:	CM15-0060544		
Date Assigned:	04/06/2015	Date of Injury:	01/18/2004
Decision Date:	05/07/2015	UR Denial Date:	03/26/2015
Priority:	Standard	Application Received:	03/30/2015

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: 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 62 year old female, who sustained a work/ industrial injury on 1/18/04. She has reported initial symptoms of neck and low back pain after carrying a scale and slipping and twisting. The injured worker was diagnosed as having lumbar herniated nucleus pulposus, lumbar degenerative disc disease (DDD), and displacement of lumbar disc without myelopathy and lumbosacral ligament sprain. Treatments to date included medications, physical therapy, injections, diagnostics, massage therapy and chiropractic. Magnetic Resonance Imaging (MRI) of the lumbar spine was performed on 2/9/15. Electromyogram/nerve conduction velocity (EMG/NCV) was performed on 5/4/09. The X-ray's of the lumbar spine were performed on 3/13/15 with gross abnormalities noted. Currently, the injured worker complains of ongoing worsening low back pain rated 7-9/10 on pain scale with burning and tingling in the bilateral lower extremities. The treating physician's report (PR-2) from 3/13/15 indicated that the physical exam of the lumbar spine revealed moderate to severe tenderness, muscle spasm, decreased range of motion with tenderness and antalgic gait. The physician noted that she had continued disabling low back pain with radicular complaints in the bilateral lower extremities, instability at the lumbar level with facet arthrosis, and disc protrusions with compression with radicular complaints lower extremities. Treatment plan included L5-S1 axial lumbar interbody fusion, posterior fusion with instrumentation, two day inpatient stay, Intraoperative neurophysiological testing, Pre-operative exam with electrocardiogram (EKG), Pre-operative chest report, pre-operative labs (CBC, CMP, PT, PTT, UA), Lumbar brace, Orthfix bone growth stimulator, Fourteen day rental of a vascultherm cold therapy unit, and Home health nurse

evaluation plus two visits for skilled observation of wound, pain management, neurological status, home safety and equipment needs, three visits.

IMR ISSUES, DECISIONS AND RATIONALES

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

L5-S1 axial lumbar interbody fusion, posterior fusion with instrumentation, two day inpatient stay: 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.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-307.

Decision rationale: The California MTUS guidelines do recommend a spinal fusion for traumatic vertebral fracture, dislocation and instability. This patient has not had any of these events. The provider mentions films that show 3 mm of movement at L5-S1 but the documentation does not provide any report to support this statement. The California MTUS guidelines note that surgical consultation is indicated if the patient has persistent, severe and disabling lower extremity symptoms. The documentation shows this patient has been complaining of back pain with tingling and burning in the legs. Documentation does not disclose disabling lower extremity symptoms. The guidelines also list the criteria for clear clinical, imaging and electrophysiological evidence consistently indicating a lesion which has been shown to benefit both in the short and long term from surgical repair. Documentation does not show this evidence. The requested treatment is for a lumbar interbody fusion and posterior fusion with instrumentation. The guidelines note that the efficacy of fusion without instability has not been demonstrated. Documentation does not show instability. The requested treatment: L5-S1 axial lumbar interbody fusion, posterior fusion with instrumentation, two day inpatient stay is NOT medically necessary and appropriate.

Intraoperative neurophysiological testing: 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.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Since the requested treatment: L5-S1 axial lumbar interbody fusion, posterior fusion with instrumentation, two day inpatient stay is NOT medically necessary and appropriate, then the Requested Treatment: Intraoperative neurophysiological testing is NOT medically necessary and appropriate.

Decision rationale: Since the requested treatment: L5-S1 axial lumbar interbody fusion, posterior fusion with instrumentation, two day inpatient stay is NOT medically necessary and

appropriate, then the Requested Treatment: Intraoperative neurophysiological testing is NOT medically necessary and appropriate.

Pre-operative exam with EKG: 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.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Since the requested treatment: L5-S1 axial lumbar interbody fusion, posterior fusion with instrumentation, two day inpatient stay is NOT medically necessary and appropriate, then the Requested Treatment: Pre-operative exam with EKG is NOT medically necessary and appropriate.

Decision rationale: Since the requested treatment: L5-S1 axial lumbar interbody fusion, posterior fusion with instrumentation, two day inpatient stay is NOT medically necessary and appropriate, then the Requested Treatment: Pre-operative exam with EKG is NOT medically necessary and appropriate.

Pre-operative chest report, pre-operative labs (CBC, CMP, PT, PTT, UA): 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.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Since the requested treatment: L5-S1 axial lumbar interbody fusion, posterior fusion with instrumentation, two day inpatient stay is NOT medically necessary and appropriate, then the Requested Treatment: Pre-operative chest report, pre-operative labs (CBC, CMP, PT, PTT, UA) is NOT medically necessary and appropriate.

Decision rationale: Since the requested treatment: L5-S1 axial lumbar interbody fusion, posterior fusion with instrumentation, two day inpatient stay is NOT medically necessary and appropriate, then the Requested Treatment: Pre-operative chest report, pre-operative labs (CBC, CMP, PT, PTT, UA) is NOT medically necessary and appropriate.

Lumbar brace: 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.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Since the requested treatment: L5-S1 axial lumbar interbody fusion, posterior fusion with instrumentation, two day inpatient stay is NOT medically necessary and appropriate, then the Requested Treatment: Lumbar brace is NOT medically necessary and appropriate.

Decision rationale: Since the requested treatment: L5-S1 axial lumbar interbody fusion, posterior fusion with instrumentation, two day inpatient stay is NOT medically necessary and appropriate, then the Requested Treatment: Lumbar brace is NOT medically necessary

and appropriate.

Orthfix bone growth stimulator: 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.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Since the requested treatment: L5-S1 axial lumbar interbody fusion, posterior fusion with instrumentation, two day inpatient stay is NOT medically necessary and appropriate, then the Requested Treatment: Orthfix bone growth stimulator is NOT medically necessary and appropriate.

Decision rationale: Since the requested treatment: L5-S1 axial lumbar interbody fusion, posterior fusion with instrumentation, two day inpatient stay is NOT medically necessary and appropriate, then the Requested Treatment: Orthfix bone growth stimulator is NOT medically necessary and appropriate.

Fourteen day rental of a vascultherm cold therapy unit: 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.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Since the requested treatment: L5-S1 axial lumbar interbody fusion, posterior fusion with instrumentation, two day inpatient stay is NOT medically necessary and appropriate, then the Requested Treatment: Fourteen day rental of a vascultherm cold therapy unit is NOT medically necessary and appropriate.

Decision rationale: Since the requested treatment: L5-S1 axial lumbar interbody fusion, posterior fusion with instrumentation, two day inpatient stay is NOT medically necessary and appropriate, then the Requested Treatment: Fourteen day rental of a vascultherm cold therapy unit is NOT medically necessary and appropriate.

Home health nurse evaluation plus two visits for skilled observation of wound, pain management, neurological status, home safety and equipment needs, three visits: 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.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Since the requested treatment: L5-S1 axial lumbar interbody fusion, posterior fusion with instrumentation, two day inpatient stay is NOT medically necessary and appropriate, then the Requested Treatment: Home health nurse evaluation plus two visits for skilled observation of wound, pain management, neurological status, home safety and equipment needs, three visits is NOT medically necessary and appropriate.

Decision rationale: Since the requested treatment: L5-S1 axial lumbar interbody fusion,

posterior fusion with instrumentation, two day inpatient stay is NOT medically necessary and appropriate, then the Requested Treatment: Home health nurse evaluation plus two visits for skilled observation of wound, pain management, neurological status, home safety and equipment needs, three visits is NOT medically necessary and appropriate.