MAXIMUS Federal Services

Case Number:	CM15-0071097		
Date Assigned:	04/21/2015	Date of Injury:	08/24/2012
Decision Date:	05/22/2015	UR Denial Date:	04/13/2015
Priority:	Standard	Application Received:	04/14/2015

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: Illinois, California, 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 35-year-old female who sustained an industrial injury on 8/24/12. Past surgical history was positive for left shoulder arthroscopic surgery in 2010, left shoulder manipulation under anesthesia in 2011, carpal tunnel releases in 2012-2013, and right foot bunion surgery in 2013. The 3/10/14 lumbar spine MRI impression documented advanced chronic discogenic disease with on-going motion segment instability at L5/S1 with relatively low-profile broad-based protrusion, moderate foraminal narrowing, and small disc protrusion in contact with the undersurface of exiting right L5 nerve root. Findings documented acute on chronic Modic change as an indication of stress response or motion segmental instability. There was a low-profile protrusion and high intensity zone at L4/5, and fissuring might contribute to pain. The 4/6/15 neurosurgical report cited on-going 10/10 back pain and pain radiating down the legs with weakness and numbness. MRI demonstrated evidence of degenerative disc disease and foraminal narrowing at the L5/S1. The injured worker had failed physical therapy, injection, and acupuncture. Medications included Percocet, Valium and Trazadone. She had been unable to tolerate work duties as a housekeeper. Physical exam documented mild to moderate distress, with normal extremity muscle tone and bulk. There was some mild weakness of right plantar flexion. There was decreased pinprick sensation at the S1 dermatome. The treatment plan recommended L5/S1 decompression and fusion. The 4/13/15 utilization review modified the request for right L5/S1 decompression and fusion and partially certified a right L5/S1 decompression as there was no radiographic or imaging evidence suggestive of instability. The request for non-specific pre-operative testing was partially certified for a complete blood count

and basic metabolic panel. The request for 3-day hospital stay was partially certified for 1 day hospital stay consistent with the certification of decompression surgery. The 4/21/15 neurosurgical letter stated that the injured worker presented with symptoms of back pain radiating down both lower extremity with work-up demonstrating evidence of foraminal narrowing. As she had failed all conservative measures, it was recommended that she undergo a lumbar laminectomy and fusion. The fusion component was denied and only the decompression authorized. She had predominantly back pain rather than radiculopathy. A laminectomy alone was not indicated to address the back pain; fusion was a sensible surgical alternative. If fusion was not authorized, there was no surgery to be done.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right L5-S1 decompression and fusion: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 306. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back, Indications for Surgery, Discectomy/Laminectomy.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-307. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Lumbar & Thoracic, Discectomy/Laminectomy, Fusion (spinal).

Decision rationale: The California MTUS guidelines recommend decompression surgery for lumbosacral nerve root decompression. Guidelines state there is no good evidence that spinal fusion alone was effective for treating any type of acute low back problem, in the absence of spinal fracture, dislocation, or spondylolisthesis if there was instability and motion in the segment operated on. Before referral for surgery, consideration of referral for psychological screening is recommended to improve surgical outcomes. The Official Disability Guidelines recommend laminectomy for lumbar spinal stenosis. Surgical indications include imaging evidence with concordance between radicular findings on radiologic evaluation and physical exam findings, and conservative treatment. Fusion is recommended for objectively demonstrable segmental instability, such as excessive motion with degenerative spondylolisthesis. Fusion may be supported for surgically induced segmental instability. Pre-operative clinical surgical indications require completion of all physical therapy and manual therapy interventions, x-rays demonstrating spinal instability, spine pathology limited to 2 levels, and psychosocial screening with confounding issues addressed. Guideline criteria have not been fully met. This patient presents with persistent severe low back pain radiating down the legs with weakness and numbness. She has been unable to return to work. Clinical exam findings are consistent with imaging evidence of nerve root compression at L5/S1. Detailed evidence of a recent, reasonable and/or comprehensive non-operative treatment protocol trial and failure has been submitted. The 4/13/15 utilization review partially certified a right L5/S1 decompression as there was no radiographic or imaging evidence suggestive of instability to support fusion. There are imaging findings suggestive of motion segmental instability at L5/S1, however this is not supported by flexion/extension films. Additionally, there are potential psychological factors noted with no

evidence of psychosocial clearance. Therefore, this request is not medically necessary at this time.

Pre-operative 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), Criteria for Preoperative lab testing.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Practice advisory for preanesthesia evaluation: an updated report by the American Society of Anesthesiologists Task Force on Preanesthesia Evaluation. Anesthesiology 2012 Mar; 116(3): 522-38.

Decision rationale: The California MTUS guidelines do not provide recommendations for this service. Evidence based medical guidelines indicate that a basic pre-operative assessment is required for all patients undergoing diagnostic or therapeutic procedures. Guidelines indicate that most laboratory tests are not necessary for routine procedures unless a specific indication is present. Indications for such testing should be documented and based on medical records, patient interview, physical examination, and type and invasiveness of the planned procedure. The 4/13/15 utilization review partially certified this non-specific request for pre-operative testing and allowed a complete blood count and basic metabolic panel. There is no compelling reason to support the medical necessity of additional testing in the absence of a specific request. Therefore, this request is not medically necessary.

3 day hospital 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, Hospital length of stay.

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: Hospital length of stay (LOS).

Decision rationale: As the surgical request is not supported, this request is not medically necessary. The California MTUS does not provide hospital length of stay recommendations. The Official Disability Guidelines recommend the median length of stay (LOS) based on type of surgery, or best practice target LOS for cases with no complications. The recommended median and best practice target for anterior or posterior lumbar fusion is 3 days. The 4/13/15 utilization review modified the request for 3-day hospital stay to 1-day hospital stay consistent with lumbar decompression surgery. As the lumbar fusion has not been determined to be medically necessary at this time, additional length of stay is not supported. Therefore, this request is not medically necessary.