

Case Number:	CM13-0035676		
Date Assigned:	04/25/2014	Date of Injury:	11/26/2012
Decision Date:	07/18/2014	UR Denial Date:	09/11/2013
Priority:	Standard	Application Received:	10/17/2013

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 California. 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 41-year-old male who reported an injury on November 26, 2012. The mechanism of injury was not provided for review. The injured worker underwent an electrodiagnostic study in March 2013 that documented the injured worker had chronic right L5 radiculopathy and chronic left L4 radiculopathy. The injured worker underwent an MRI in January 2013 that documented there was a disc bulge measuring 4mm to 5mm with no central canal narrowing and only mild bilateral neural foraminal narrowing. The injured worker was evaluated on July 18, 2013. It was documented that the injured worker had continued low back pain complaints that radiated into the bilateral lower extremities. The injured worker's physical findings included a positive straight leg raising test bilaterally and decreased sensation in the L4-5 and L5-S1. It was documented that the injured worker was nonresponsive to nonoperative treatment. The injured worker's treatment history included physical therapy, medications, and an epidural steroid injection. A request for anterior posterior decompression and fusion at the L4-5 and L5-S1 was made on September 04, 2013. However, no clinical documentation was submitted to support the request in September 2013. The injured worker was evaluated on October 31, 2013. Physical findings included decreased range of motion and spasming with a negative straight leg raising test and 5/5 lower extremity motor strength. The injured worker's treatment plan included surgical intervention.

IMR ISSUES, DECISIONS AND RATIONALES

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

AN ASSISTANT SURGEON: Overturned

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 Chapter, Surgical assistant; and the American College of Surgeons, Physician as Assistant Surgeons, a 2011 Case Study.

Decision rationale: The requested assistant surgeon is medically necessary and appropriate. The California MTUS/ACOEM Occupational Medical Practice Guidelines do not address this request. The Official Disability Guidelines recommend a surgical assistant as an option for more complex surgeries. The clinical documentation submitted for review indicates that the surgical request is for a fusion. This complex surgery would benefit from an additional surgical assistant on the surgical team. Additionally, the American College of Surgeons, Physicians as Assistant Surgeons, a 2011 case study, states that an assistant surgeon is almost always needed for a surgical fusion. As such, the request is medically necessary and appropriate.

A 4-DAY INPATIENT HOSPITAL STAY: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Low Back chapter, Inpatient Hospital Stay 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 Chapter, Hospital Length of Stay.

Decision rationale: The requested 4-day inpatient hospital stay is not medically necessary or appropriate. The California MTUS/ACOEM Occupational Medical Practice Guidelines do not address this request. The Official Disability Guidelines recommend up to a 3-day inpatient stay following lumbar fusion. In the absence of complicating diagnoses, an additional inpatient stay would not be supported. As such, the request is not medically necessary or appropriate.

PRESCRIPTION OF EDULAR 10MG: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Pain Chapter and the Physicians Desk Reference.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter, Insomnia Treatments.

Decision rationale: The requested Edluar 10 mg is not medically necessary or appropriate. The California MTUS/ACOEM Occupational Medical Practice Guidelines do not address this

request. The Official Disability Guidelines do not support the long-term use of this medication. The clinical documentation submitted for review does indicate that the patient has been on this medication since at least July 2013. Additionally, the clinical documentation does not adequately address the injured worker's sleep hygiene to support extending treatment beyond guideline recommendations. Furthermore, the request as it is submitted does not clearly identify a frequency or duration of treatment. In the absence of this information, the appropriateness of the request itself cannot be determined. As such, the request is not medically necessary or appropriate.

PRESCRIPTION OF AMRIX 15MG #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants Page(s): 63.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines MUSCLE RELAXANTS Page(s): 63.

Decision rationale: The requested Amrix 15mg (#30) is not medically necessary or appropriate. The Chronic Pain Medical Treatment Guidelines do not recommend the use of muscle relaxants in the management of chronic pain. Guidelines recommend that muscle relaxants be used for short durations of treatment not to exceed 2 to 3 weeks for acute exacerbations of chronic pain. The clinical documentation does indicate that the injured worker has been on this medication since at least July 2013. As the patient has been on this medication for a duration of time that exceeds guideline recommendations, continued use would not be supported. Additionally, the request as it is submitted does not provide a frequency of treatment. In the absence of this information, the appropriateness of the request itself cannot be determined. As such, the request is not medically necessary or appropriate.

PRESCRIPTION OF NORCO: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 79-81.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines OPIOIDS, ON-GOING MANAGEMENT Page(s): 78.

Decision rationale: The requested prescription of Norco is not medically necessary or appropriate. The California MTUS recommends the ongoing use of opioids in the management of chronic pain be supported by documentation of functional benefit, a quantitative assessment of pain relief, managed side effects, and evidence that the injured worker is monitored for aberrant behavior. The clinical documentation submitted for review does indicate that the patient has been on this medication since at least July 2013. However, the clinical documentation fails to provide any evidence that the patient is monitored for aberrant behavior, has any functional benefit from medication usage, and no evidence of pain relief. Furthermore, the request as it is submitted does not clearly identify a dosage frequency or quantity. In the absence of this information, the

appropriateness of the request itself cannot be determined. As such, the request is not medically necessary or appropriate.

A FRONT WHEELED WALKER: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Medicare National Coverage Determinations Manual.

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 Chapter, Walking Aids.

Decision rationale: The requested front wheeled walker is not medically necessary or appropriate. The California MTUS/ACOEM Occupational Medical Practice Guidelines do not address this request. The Official Disability Guidelines recommend assisted ambulation for patients who have deficits that put them at risk for injury. However, all lower levels of equipment should be excluded prior to prescription of a wheeled walker. The clinical documentation does indicate that the patient is going to undergo fusion surgery. Preventative measures for falls and reduction of risk of further injury post-surgically would be indicated; however, there is no documentation of why a cane could not sufficiently address any postsurgical ambulation deficits. As such, the request is not medically necessary or appropriate.

A THORACOLUMBOSACRAL (TLSO) BACK BRACE: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 301. Decision based on Non-MTUS Citation ODG, Low Back Chapter.

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 Chapter, Back brace, post operative (fusion).

Decision rationale: The requested thoracolumbosacral (TLSO) back brace is medically necessary and appropriate. The California MTUS/ACOEM Occupational Medical Practice Guidelines do not address this request. The Official Disability Guidelines recommend postsurgical lumbar supports for patients who have special circumstances to include a multilevel fusion. The clinical documentation submitted for review does indicate that the patient will undergo surgical intervention at L4-5 and L5-S1. Therefore, the need for a lumbar support in this clinical situation is indicated. As such, the request is medically necessary and appropriate.

3-IN-1 COMMUNE: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Medicare Part B.

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 Chapter, Durable Medical Equipment.

Decision rationale: The requested 3-in-1 commode is not medically necessary or appropriate. The California MTUS/ACOEM Occupational Medical Practice Guidelines do not address this request. The Official Disability Guidelines recommend durable medical equipment such as a 3-in-1 commode for patients who are restricted to a single room due to severe ambulation deficits or at risk for continued injury. The clinical documentation does indicate that the patient will undergo fusion surgery; however, there is no justification to support that the patient will be required to stay in one room and could not safely ambulate with an assistive device to a bathroom. Therefore, a 3-in-1 commode is not indicated in this clinical situation. As such, the request is not medically necessary or appropriate.

COLD THERAPY UNIT: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation PubMed.

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 Chapter, Cold/heat packs.

Decision rationale: The requested cold therapy unit is not medically necessary or appropriate. The California MTUS/ACOEM Occupational Medical Practice Guidelines do not address this request. The Official Disability Guidelines do not recommend the use of a cold therapy unit in the management of postsurgical pain related to low back surgery. There are no exceptional factors noted within the documentation to support extending treatment beyond guideline recommendations. Additionally, the request as it is submitted does not clearly identify a duration of treatment or whether the equipment is for rental or purchase. In the absence of this information, the appropriateness of the request itself cannot be determined. As such, the request is not medically necessary or appropriate.

BONE GROWTH STIMULATOR: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Neck and Upper Back.

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 Chapter, Bone growth stimulators (BGS).

Decision rationale: The requested bone growth stimulator is not medically necessary or appropriate. The California MTUS/ACOEM Occupational Medical Practice Guidelines do not address this request. The Official Disability Guidelines recommend the use of a bone growth stimulator for multilevel fusion surgery. The clinical documentation does indicate that the patient

is going to undergo a two level fusion surgery; however, the request as it is submitted does not clearly identify a duration or frequency of treatment. Therefore, the appropriateness of the request itself cannot be determined. As such, the request is not medically necessary or appropriate.