

Case Number:	CM14-0155562		
Date Assigned:	09/25/2014	Date of Injury:	01/12/2010
Decision Date:	11/24/2014	UR Denial Date:	09/16/2014
Priority:	Standard	Application Received:	09/23/2014

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. The expert reviewer is Board Certified Orthopedic Spine Surgeon and is licensed to practice in Texas. 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 55-year-old m who reported an injury on 01/12/2010 due to an unknown mechanism of injury. The injured worker reportedly sustained an injury to his cervical and lumbar spine and suffered emotional distress. Diagnostic studies included an MRI of the cervical spine dated 10/29/2014, a lumbar MRI dated 06/27/2014. The MRI of the lumbar spine documented a disc protrusion at the L2-L3, indenting the exiting left and right L2 exiting nerve roots, and a disc bulge at the L3-L4, impinging the exiting left and right L3 exiting nerve roots. The injured worker was evaluated on 08/14/2014. It was documented that the injured worker had chronic low back pain rated 10/10 that was decreased by 50% with medications. Physical findings included a positive straight leg raising test bilaterally, decreased motor strength rated 4/5 in the S1 dermatomal distribution, with significantly limited ambulation secondary to pain. The injured worker's treatment plan included an anterior posterior spinal fusion from the L2 to the L5, a home exercise program, and a refill of medications. Updated MRIs due to increased back pain and the neck and low back were also requested. No Request for Authorization form was submitted to support the request.

IMR ISSUES, DECISIONS AND RATIONALES

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

Norco 10.325mg#180: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, On-going Management Page(s): 78.

Decision rationale: The requested Norco 10/325 mg #180 is not medically necessary or appropriate. The California Medical Treatment Utilization Schedule recommends the ongoing use of opioids in the management of chronic pain be supported by documented functional benefit, a quantitative assessment of pain relief, managed side effects, and evidence that the patient is monitored for aberrant behavior. The clinical documentation submitted for review does not provide any evidence of significant functional improvement related to medication usage. It is noted that the injured worker has a 50% reduction in pain due to medication usage. Additionally, there is no documentation that the injured worker is monitored for aberrant behavior. Furthermore, the request as it is submitted does not clearly identify a frequency of treatment. In the absence of this information, the appropriateness of the request itself cannot be determined. As such, the requested Norco 10/325 mg #180 is not medically necessary or appropriate.

MRI Neck: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 178.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-179.

Decision rationale: The requested MRI of the neck is not medically necessary or appropriate. The clinical documentation submitted for review does indicate that the injured worker has recently undergone an MRI of the neck. Official Disability Guidelines do not support repeat imaging in the absence of significantly progressive neurological deficits or a change in the injured worker's clinical presentation to support the need for an additional MRI. The clinical documentation submitted for review does not provide any evidence that the patient has had a significant change in clinical presentation or a significant change in the patient's neurological deficits since the previous MRI. Therefore, an additional MRI would not be supported. As such, the requested MRI of the neck is not medically necessary or appropriate.

MRI Lumbar Spine: 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): 307.

Decision rationale: The requested MRI of the lumbar spine is not medically necessary or appropriate. Official Disability Guidelines do not support the use of repeat imaging unless there is a significant change in the patient's clinical presentation or severe progressive neurological

deficits. The clinical documentation submitted for review does not provide any evidence that the injured worker has had severe progressive neurological deficits or a significant change in clinical presentation since the last MRI dated 06/27/2014. Therefore, an additional MRI of the lumbar spine would not be supported in this clinical situation. As such, the requested MRI of the lumbar spine is not medically necessary or appropriate.

Fusion Lumbar L2-5 ASF/PSF: Upheld

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

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

Decision rationale: The requested fusion lumbar L2-L5 ASF/PSF is not medically necessary or appropriate. The American College of Occupational and Environmental Medicine recommends fusion surgery for patients with documented instability and disabling radicular symptoms that have failed to respond to conservative treatment and have evidence of instability on an imaging study that would benefit from hardware stabilization. The clinical documentation submitted for review does indicate that the injured worker underwent an MRI on 06/27/2014. However, an independent reading of this MRI was not provided for review. Therefore, surgical intervention would not be supported in this clinical situation as there is no way to definitively identify the potential for instability. Additionally, the American College of Occupational and Environmental Medicine does not recommend spinal surgery unless the injured worker has been psychologically cleared for surgery. There is no documentation of a psychological evaluation supporting that the injured worker is a candidate for surgical intervention. As such, the requested fusion L2-L5 ASF/PSF is not medically necessary or appropriate.

Facility: Inpatient X3 Days: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

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