MAXIMUS Federal Services

| Case Number: | CM14-0020797 | | |
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| Date Assigned: | 07/02/2014 | Date of Injury: | 11/30/1983 |
| Decision Date: | 09/30/2014 | UR Denial Date: | 02/12/2014 |
| Priority: | Standard | Application Received: | 02/19/2014 |

## 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 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 claimant is a 57-year-old gentleman who was injured in a work related accident on November 30, 1983. The medical records provided for review document a long and lengthy course of care in regards to the claimant's low back including an anterior and posterior fusion at the L5-S1 level in 2012 followed by a September 2013 hardware removal due to continued pain. The report of an MRI dated December 17, 2013, revealed disc space loss at the L4-5 level with foraminal narrowing bilaterally. There were postsurgical changes consistent with the prior fusion at the L5-S1 level and evidence of hardware removal with pedicle screw tracks. The report of the April 21, 2014 follow up noted continued low back and bilateral leg complaints worse with activities. Physical exam showed 5/5 strength with plantar and dorsiflexion, severe paraspinous muscle spasm, positive bilateral straight leg raising reproducing pain into the low back, and no documented sensory or reflexive change. Reviewed at that time was the claimant's updated MRI scan of the lumbar spine. The recommendation was made for an anterior posterior lumbar fusion and decompression at L4-5.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**ANTERIOR AND POSTERIOR LUMBAR FUSION AND DECOMPRESSION LUMBAR 4- LUMBAR 5:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Page(s): 305, 307. Decision based on Non-MTUS Citation Official Disability Guidelines, Patient Selection Criteria for Lumbar Spinal Fusion.

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

**Decision rationale:** The ACOEM Guidelines recommend fusion in the setting of lumbar fracture, dislocation, or segmental instability. While this individual is noted to have continued complaints of pain and an MRI scan showing a degenerative level at L4-5, there is no documentation of physical examination supporting a radicular process at the requested surgical level or clinical imaging supporting segmental instability at the requested surgical level. In absence of documentation as noted, the proposed surgery does not meet the ACOEM Guidelines for medical necessity. Therefore, based on California ACOEM Guidelines, the request for an anterior posterior decompression and lumbar fusion at L4-5 cannot be recommended as medically necessary.

**DME: BONE STIMULATOR PURCHASE:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation http://www.odg-twc.com/odgtwc/low_back.htm Criteria for use for invasive or non-invasive electrical bone growth stimulators.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Treatment in Worker's Comp, 18th Edition, 2013 Updates: low back procedure - Bone growth stimulators (BGS).

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

**BOA BACK BRACE PURCHASE:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 1 Prevention, Chapter 12 Low Back Complaints Page(s): 9; 298, 301.

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

**HOSPITAL STAY TIMES 2 DAYS:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, 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) Treatment in Worker's Comp, 18th Edition, 2013 Updates: low back procedure - Fusion (spinal): Hospital length of stay (LOS).

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

**ASSISTANT SURGEON:** 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 Other Medical Treatment Guideline or Medical Evidence: Milliman Care Guidelines 18th edition: assistant surgeonAssistant Surgeon Guidelines (Codes 21810 to 22856) CPTÂ® Y/N.

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

**MENTHODERM GEL:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113.

**Decision rationale:** The California MTUS Chronic Pain Guidelines do not support the use of Menthoderm gel. According to the Chronic Pain Guidelines, the use of topical agents is largely experimental with few randomized clinical controls and trials demonstrating their efficacy or benefit. Given this individual's chronic pain complaints dating back to injury in the 1980's, the acute use of this topical agent would not be supported. Therefore, the request is not medically necessary.

**PROTONIX:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs (Non-Steroidal Anti-Inflammatory).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk Page(s): 68-69.

**Decision rationale:** The California MTUS Chronic Pain Guidelines do not support the continued use of protonix. The medical records do not document that the claimant has a GI risk factor to support the use of this protective proton pump inhibitor. Chronic Pain Guidelines recommend the use of a protective protein pump inhibitor for people greater than 65 years old or those with a history of peptic ulcer, GI bleeding or perforation, concordant use of aspirin, corticosteroids, anticoagulants, and/or high dose multiple nonsteroidal usage. Therefore, the use of protonix is not recommended as medically necessary.