

Case Number:	CM14-0024063		
Date Assigned:	02/28/2014	Date of Injury:	07/16/2004
Decision Date:	06/30/2014	UR Denial Date:	12/30/2013
Priority:	Standard	Application Received:	01/10/2014

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, has a Fellowship trained in Spine 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 53-year-old female who reported an injury on 07/15/2004. The mechanism of injury was the injured worker was helping unload a merchandise delivery when she felt a sharp crack in her back. The injured worker had electrodiagnostic studies on 10/29/2012 which revealed bilateral S1 radiculopathy. The medication history included opiates and muscle relaxants as of 06/2013. The injured worker underwent an MRI on 06/17/2013, which revealed at the level of L5-S1 there was diffuse lumbar spondylosis, most pronounced at L5 through S1. Approximately 2-3 mm broad based right eccentric disc protrusion encroaches upon, but does not compress or displace, the descending right S1 nerve root. The disc protrusion is in conjunction with posterior osteophyte ridging and mild facet arthropathy, resulting in mild narrowing of the left neural foramen without evidence of nerve root impingement. The physical examination dated 11/20/2013 revealed the injured worker has been treated with physical therapy, medications, electrical stimulation, hot towel compression and acupuncture, and epidural steroid injections for her neck and back as recent as 08/2012. The injured worker indicated that she had sharp, stabbing and burning pain in the upper, mid, and low back radiating down to the lower extremities and extending to her legs, which was rated an 8/10. The injured worker had numbness and tingling in the legs. The injured worker had weakness in the lower extremities. Physical examination of the lumbar spine revealed severe limitation of mobility due to muscle spasms. The sciatic stretch signs were markedly positive on the right in both the seated and supine position at 50-60 degrees. There was decreased sensation in the L5-S1 distribution. There was weakness of the L5-S1 innervated musculature. Toe walk and heel walk produced a markedly antalgic gait on the right. Diagnostic x-rays taken on that revealed narrowing of the L5-S1 disc. The diagnoses included right-side L5-S1 disc herniation. The treatment plan included an L5-S1 posterior interbody fusion and decompression, DME and postoperative

medications as well as physical therapy, including a pro-stim unit, postsurgical use of a motorized hot/cold therapy unit, back brace, 3/1 commode, front-wheeled walker, physical therapy, and home health, with the duration and frequency to be determined postoperatively. Postoperative medications include Zofran, Duricef and Norco. Additionally, the treatment plan included an inpatient surgical procedure stay for 2 days, postoperative evaluation by an RN, and a postoperative follow-up. Additionally, the medications Cyclobenzaprine and Tramadol were renewed.

IMR ISSUES, DECISIONS AND RATIONALES

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

AUTHORIZATION FOR SPINE SURGERY IN THE FORM OF L5-S1 POSTERIOR LUMBAR INTERBODY FUSION AND DECOMPRESSION: 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), Lumbar Spine Guidelines.

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 Chapter, Laminectomy

Decision rationale: The ACOEM indicate a surgical consultation is appropriate for injured workers who have severe and disabling lower leg symptoms in a distribution consistent with abnormalities on imaging studies, radiculopathy preferably with accompanying objective signs of neurocompromise, activity limitations due to radiating leg pain for more than 1 month, or extreme progression of lower leg symptoms, clear clinical, imaging and electrophysiologic evidence of a lesion that has been shown to benefit in both the long and short-term from surgical repair, and a failure of conservative treatment to resolve disabling radicular symptoms. The direct methods of nerve root decompression include a laminotomy, standard discectomy, and laminectomy. However, they do not specifically address the criteria for a decompression. As such, secondary guidelines were sought. Per the Official Disability Guidelines the indication for a discectomy/laminectomy includes symptoms or findings which confirm the presence of radiculopathy, and there should be objective findings on examination, including a positive straight leg raise test, positive cross leg raise test, and reflex examinations that correlate with the symptoms on imaging. For the level of L5, there should be nerve root compression requiring 1 of the following: severe unilateral foot/toe/dorsiflexor weakness/mild atrophy, mild to moderate foot/toe, or mild to moderate foot/toe/dorsiflexor weakness or unilateral hip/lateral thigh/knee pain. For the level of S1 nerve root compression, there should be severe unilateral foot/toe/plantar flexor or hamstring weakness/atrophy, or mild unilateral foot/toe/plantar flexor/hamstring weakness, or unilateral buttock/posterior thigh/calf pain. The imaging studies include nerve root compression or lateral disc rupture, or lateral recess stenosis per MRI. Conservative treatments require activity modification for greater than 2 months, drug therapy, including muscle relaxants or epidural steroid injection, and support provider referral requiring physical therapy or psychological screening that could affect surgical outcome. The clinical documentation submitted for review indicated she had low back pain radiating to bilateral

extremities. The sciatic stretch signs were positive in both the seated and supine position. The injured worker had decreased sensation in the L5-S1 distribution and weakness of the L5-S1 musculature. Per electrodiagnostics, the injured worker had bilateral S1 radiculopathy. At the level of L5-S1 there was no compression on the descending right S1 nerve root. There was no documentation of a lateral disc rupture, nor lateral recess stenosis. The conservative treatments included activity modification, drug therapy including muscle relaxants and NSAIDs, and physical therapy. As there was no nerve root compression, lateral disc rupture, or lateral recess stenosis per MRI, this portion of the request would not be supported. The ACOEM guidelines indicate that ther

AUTHORIZATION FOR PRO-STIM UNIT WITH SUPPLIES: 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.

MOTORIZED HOT/COLD THERAPY UNIT: 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.

BACK BRACE: 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.

3/1 COMMODE: 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.

FRONT-WHEEL WALKER: 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.

HOME HELP POST-OP: 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.

PSYCHOLOGICAL CLEARANCE FOR SURGICAL INTERENTION: 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.

TWO-DAY HOSPITAL STAY: 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.

POSTOPERATIVE EVALUATION BY AN R.N.: 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.

POSTOP FOLLOW UP WITH [REDACTED] FOR 4-5 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.

ZOFRAN 4MG PO, (POSTOP MEDICATIONS): 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.

DURACEF, (POSTOP MEDICATIONS): 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.

NORCO 5/325 MG 1 PO (POSTOP MEDICATIONS): 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.

NAPROXEN 50MG 1 P.O.12H WITH FOOD, #100: 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), Lumbar Spine Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS Page(s): 67.

Decision rationale: The California MTUS Guidelines recommend NSAIDs for the short-term treatment of acute low back pain. There should be documentation of objective functional improvement and an objective decrease in pain. The clinical documentation submitted for review indicated the injured worker had been utilizing the medication for greater than 5 months. There was a lack of documentation of objective functional benefit and an objective decrease in pain. Given the above, the request for naproxen 50 mg, 1 by mouth every 12 hours with food #100 is not medically necessary.