MAXIMUS Federal Services

Case Number:	CM14-0033095		
Date Assigned:	06/20/2014	Date of Injury:	01/11/2007
Decision Date:	09/10/2014	UR Denial Date:	02/19/2014
Priority:	Standard	Application Received:	03/12/2014

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 patient is a 62 year-old female who has submitted a claim for HNP and spinal cord compression associated with an industrial injury date of 01/11/2007.Medical records from 2013 were reviewed. The most recent progress report available was dated 10/22/2013 stating that the patient complained of low back pain radiating to the right lower extremity. A physical examination from 06/14/2013 cited slight muscle bulk discrepancy at the right calf (34.5 cm) versus left (36 cm). Ankle reflexes and sensation to vibration were absent. MRI of the lumbar spine, dated 06/10/2013, revealed status post anterior interbody fusions at the L4-L5 and L5-S1 disc levels with new heterotopic ossification posterior to the intradiscal fusion cages, particularly at the L4-L5 level with compression and deformity on the right ventral epidural space and mild compression on the intraspinal right L5 nerve root sleeve. There was extensive postsurgical epidural fibrosis encasing the intraspinal right L5 and S1 nerve root sleeves extending dorsally back to the laminectomy defects.EMG/NCV studies of the bilateral lower extremities, dated 05/31/2013, showed bilateral L5 and S1 nerve root impingement and a severe peripheral neuropathy, with axon loss and demyelination.Treatment to date has included lumbar epidural steroid injection, posterior transpedicular screw and rod fixation with bilateral lateral fusions from L4 down to S1, physical therapy, and medications.Utilization review from 02/19/2014 denied the requests for laminectomy posterior spinal fusion with instrumentation with post lateral interbody fusion L3-4, 5-day inpatient hospital stay, fentanyl, 3-in-1 commode, front wheel walker, custom-molded TLSO brace, medical clearance, and assistant surgeon; modified the request for Neurontin into Neurontin 300 mg x one month supply; modified the request for Norco into Norco 5 mg / 325mg #60, modified the request for Soma into Soma 250 mg, #20, and modified the request for Naprosyn into Naprosyn 250 mg x one month supply. Reasons for denial and modification were not made available.

IMR ISSUES, DECISIONS AND RATIONALES

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

Laminectomy Posterior Spinal Fusion with Instrumentation with Post Lateral Interbody Fusion L3-4: Upheld

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

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 Section, Fusion (spinal).

Decision rationale: Pages 305 - 307 of CA MTUS ACOEM Guidelines state that lumbar surgical intervention is recommended for patients who have: severe lower leg symptoms in the distribution consistent with abnormalities on imaging studies, preferably with accompanying objective signs of neural compromise; activity limitations for more than one month; clear imaging of a lesion; and failure of conservative treatment to resolve disabling radicular symptoms. In addition, ODG states that the patient should refrain from smoking for at least 6 weeks prior to surgery. In this case, the patient underwent posterior transpedicular screw and rod fixation with bilateral lateral fusions from L4 down to S1 on an unspecified date; however, she continued to complain of low back pain radiating to the right lower extremity. MRI of the lumbar spine, dated 06/10/2013, revealed new heterotopic ossification posterior to the intradiscal fusion cages, particularly at the L4-L5 level with compression and deformity on the right ventral epidural space and mild compression on the intraspinal right L5 nerve root sleeve. However, there was no documented rationale for the requested surgical procedure. The most recent progress report available was dated 10/22/2013 without a comprehensive physical examination to support the request. The current clinical and functional status of the patient is unknown. The medical necessity cannot be established due to insufficient information. Therefore, the request for Laminectomy Posterior Spinal Fusion with Instrumentation with Post Lateral Interbody Fusion L3-4 is not medically necessary.

5-day Inpatient 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.

Prescription of Neurontin: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-Epilepsy Drugs Page(s): 16-17.

Decision rationale: As stated on pages 16 - 17 of CA MTUS Chronic Pain Medical Treatment Guidelines, antidepressants, such as Pregabalin and Gabapentin, are recommended as a first line option for neuropathic pain, i.e., painful polyneuropathy. In this case, there is no documented rationale for prescribing Neurontin. It is unclear if the patient has been started on this medication due to lack of documentation. The most recent available progress report for review was dated 10/22/2013. The medical necessity cannot be established due to insufficient information. Moreover, the request failed to specify dosage, frequency of intake, and quantity to be dispensed. Therefore, the request for Neurontin is not medically necessary.

Prescription of Norco: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 78.

Decision rationale: As stated on page 78 of CA MTUS Chronic Pain Medical Treatment Guidelines, there are 4 A's for ongoing monitoring of opioid use: pain relief, side effects, physical and psychosocial functioning and the occurrence of any potentially aberrant drug-related behaviors. The monitoring of these outcomes over time should affect therapeutic decisions and provide a framework for documentation of the clinical use of these controlled drugs. In this case, there is no documented rationale for prescribing Norco. It is unclear if the patient has been started on this medication due to lack of documentation. The most recent available progress report for review was dated 10/22/2013. The medical necessity cannot be established due to insufficient information. Moreover, the request failed to specify dosage, frequency of intake, and quantity to be dispensed. Therefore, the request for Norco is not medically necessary.

Prescription of Fentanyl: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Duragesic; Fentanyl (transdermal) Page(s): 44; 93.

Decision rationale: Page 44 of CA MTUS Chronic Pain Medical Treatment Guidelines states "Duragesic (fentanyl transdermal system) is not recommended as a first-line therapy". Furthermore, page 93 also states that Duragesic is indicated for management of persistent

chronic pain, which is moderate to severe requiring continuous, around-the-clock opioid therapy that cannot be managed by other means (e.g., NSAIDS). In this case, there is no documented rationale for prescribing Fentanyl. It is unclear if patient has been started on this medication due to lack of documentation. The most recent available progress report for review was dated 10/22/2013. The medical necessity cannot be established due to insufficient information. Moreover, the request failed to specify dosage, frequency of intake, and quantity to be dispensed. Therefore, the request for Fentanyl is not medically necessary.

Prescription of Soma: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Carisoprodol (Soma) Page(s): 29.

Decision rationale: As stated on page 29 of CA MTUS Chronic Pain Medical Treatment Guidelines, Carisoprodol (Soma) is a centrally acting skeletal muscle relaxant that is not indicated for long-term use. Carisoprodol abuse has been noted in order to augment or alter effects of other drugs such as Hydrocodone, Tramadol, Benzodiazepine and Codeine. In this case, there is no documented rationale for prescribing Soma. It is unclear if the patient has been started on this medication due to lack of documentation. The most recent available progress report for review was dated 10/22/2013. The medical necessity cannot be established due to insufficient information. Moreover, the request failed to specify dosage, frequency of intake, and quantity to be dispensed. Therefore, the request for Soma is not medically necessary.

Prescription of Naprosyn: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): 46.

Decision rationale: As stated on page 46 of the California MTUS Chronic Pain Medical Treatment Guidelines, NSAIDs are recommended at the lowest dose for the shortest period in patients with moderate to severe pain and that there is no evidence of long-term effectiveness for pain or function. In this case, there is no documented rationale for prescribing Naprosyn. It is unclear if the patient has been started on this medication due to lack of documentation. The most recent available progress report for review was dated 10/22/2013. The medical necessity cannot be established due to insufficient information. Moreover, the request failed to specify dosage, frequency of intake, and quantity to be dispensed. Therefore, the request for Naprosyn is not medically necessary.

3-In- 1 Commode: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Blue Cross of California Medical Policy Durable Medical Equipment CG-DME-10.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee Section, Durable Medical Equipment (DME).

Decision rationale: The CA MTUS does not specifically address this topic. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers Compensation, the Official Disability Guidelines (ODG), Knee Section was used instead. It states that durable medical equipment (DME) is defined as a device that can withstand repeated use, is primarily and customarily used to serve a medical purpose, generally is not useful to a person in the absence of illness or injury, and is appropriate for use in a patient's home. DME includes bathroom and toilet supplies, assistive devices, TENS unit, home exercise kits, cryotherapy, orthoses, cold/heat packs, etc. In this case, there is no documented rationale for a commode. It is unclear if patient has functional restrictions to require such equipment. The most recent available progress report for review was dated 10/22/2013; hence, the current clinical and functional status is unknown. The medical necessity cannot be established due to insufficient information. Therefore, the request for 3-in-1 commode is not medically necessary.

Front Wheel Walker: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Blue Cross of California Medical Policy Durable Medical Equipment CG-DME-10.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee Section, Durable Medical Equipment (DME).

Decision rationale: The CA MTUS does not specifically address this topic. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers Compensation, the Official Disability Guidelines (ODG), Knee Section was used instead. It states that durable medical equipment (DME) is defined as a device that can withstand repeated use, is primarily and customarily used to serve a medical purpose, generally is not useful to a person in the absence of illness or injury, and is appropriate for use in a patient's home. DME includes bathroom and toilet supplies, assistive devices, TENS unit, home exercise kits, cryotherapy, orthoses, cold/heat packs, etc. In this case, there is no documented rationale for a walker. It is unclear if patient has functional restrictions to require such equipment. The most recent available progress report for review was dated 10/22/2013; hence, the current clinical and functional status is unknown. The medical necessity cannot be established due to insufficient information. Therefore, the request for front-wheel walker is not medically necessary.

Medical Clearance: 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.

Assistant Surgeon: Upheld

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

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.