

<b>Case Number:</b>	CM14-0027993		
<b>Date Assigned:</b>	06/16/2014	<b>Date of Injury:</b>	09/07/1996
<b>Decision Date:</b>	05/01/2015	<b>UR Denial Date:</b>	02/03/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/05/2014

### 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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: Oregon, California

Certification(s)/Specialty: Neurological Surgery

### 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 62-year-old female who reported an injury on 09/07/1996. The mechanism of injury was not stated. Current diagnoses include status post lumbar spine laminectomy in 1997 and 2004, failed back syndrome, lumbar spine herniated nucleus pulposus, bilateral lower extremity radicular pain, stenosis at L3-4, and left L3 radiculitis. The injured worker presented on 12/12/2013 with complaints of 9/10 lower back pain with radiating symptoms into the left lower extremity. The injured worker was utilizing Vicodin ES and Soma. Upon examination, there was weakness in the quadriceps and iliopsoas muscles, positive straight leg raise on the left, positive femoral stretch test, decreased lumbar range of motion by 50%, diminished quadriceps reflex, and left lower extremity weakness and sensory deficit. Recommendations included an interlaminar laminotomy and decompression at L3-4 with microdiscectomy. The injured worker would require presurgical internal medicine evaluation and clearance. An assistance surgeon was also recommended, as well as postoperative physical therapy, durable medical equipment, 2 night inpatient stay, a home health evaluation, and transportation to and from the facility. There was no Request for Authorization form submitted for this review.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Thirty-six post-operative physical therapy sessions:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 298.

**MAXIMUS guideline:** Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 10.

**Decision rationale:** The California MTUS Guidelines state the initial course of therapy means one half of the number of visits specified in the general course of therapy for the specific surgery in the postsurgical physical methods treatment recommendations. Postsurgical treatment following a discectomy/laminectomy includes 16 visits over 8 weeks. The request for 36 sessions of postoperative physical therapy would exceed guideline recommendations. The request as submitted also failed to indicate a body part to be treated. Given the above, the request is not medically necessary and appropriate.

**One off the shelf lumbar brace:** Upheld

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

**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, Postoperative (Fusion).

**Decision rationale:** The Official Disability Guidelines state a back brace is currently under study following a fusion. Given the lack of evidence a standard brace is preferred over a custom postoperative brace. There is no indication that this injured worker is scheduled to undergo a lumbar fusion. The medical necessity for the requested durable medical equipment has not been established. Therefore, the request is not medically appropriate.

**One front wheeled walker:** 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 Official Disability Guidelines (ODG) Knee & Leg Chapter, Durable Medical Equipment, Walking Aids.

**Decision rationale:** The Official Disability Guidelines recommend durable medical equipment if there is a medical need and if the device or system meets Medicare's definition of durable medical equipment. Walking aids are recommended as indicated. In this case, there was no indication that this patient would be unable to independently ambulate without the use of an assistive device. The medical necessity for the requested durable medical equipment has not been established. Therefore, the request is not medically necessary and appropriate.

**Unknown transportation: 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 Official Disability Guidelines (ODG) Knee & Leg Chapter, Transportation.

**Decision rationale:** The Official Disability Guidelines recommend transportation to and from appointments for medically necessary transportation for appointments in the same community when the patient has a disability preventing them from self transport. In this case, the injured worker does not meet the above mentioned criteria. There is no indication that this injured worker is unable to provide self transportation. There is also no mention of a contraindication to public transportation. Given the above, the request is not medically necessary and appropriate.

**One prescription for Norco 7.5mg: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): s 74-82.

**Decision rationale:** The California MTUS Guidelines state a therapeutic trial of opioids should not be employed until the patient has failed a trial of nonopioid analgesics. Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects should occur. The injured worker has continuously utilized the above medication for an unknown duration. There was no mention of a failure of nonopioid analgesics. The request as submitted also failed to indicate a frequency and quantity. Given the above, the request is not medically necessary and appropriate.

**Soma 350mg #60: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): s 63-66.

**Decision rationale:** The California MTUS Guidelines state muscle relaxants are recommended as nonsedating second line options for short term treatment of acute exacerbations. Soma should not be used for longer than 2 to 3 weeks. The injured worker has continuously utilized the above medication for an unknown duration. The guidelines do not support long term use of muscle

relaxants. The request as submitted also failed to indicate a frequency. Given the above, the request is not medically necessary and appropriate.