

<b>Case Number:</b>	CM14-0034836		
<b>Date Assigned:</b>	07/23/2014	<b>Date of Injury:</b>	02/20/1973
<b>Decision Date:</b>	01/06/2015	<b>UR Denial Date:</b>	03/12/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/20/2014

### 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 subspecialty in Orthopedic 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 64-year-old male who reported an injury on an unspecified date due to an unspecified mechanism of injury. An MRI of the lumbar spine dated 03/20/2014, shows at the L5-S1 there was a broad based disc bulge on the right in the posterolateral extension, along with moderate right foraminal narrowing with contact with the exiting L5 rootlet; facet arthropathy was moderate to prominent, and resulted in mild anterolisthesis of the L5 on S1, and there was borderline mild canal to lateral recess stenosis that was noted to be stable. On 02/24/2014, he reported neck and constant low back pain rated at a 4/10 to 5/10 with associated weakness of the bilateral legs. He also noted pain in the buttocks that radiated down into the feet, and noted numbness in the feet with radiating into the toes. His medications included OxyContin for pain. A physical examination of the lumbar spine showed paraspinal muscle spasms and tenderness to palpation. There was positive sciatic notch tenderness bilaterally. Straight leg raise was positive at 45 degrees of elevation, and all remaining orthopedic tests were negative bilaterally. Sensation revealed decreased sensation over the lateral and dorsal aspect of the feet and posterolateral calf and motor strength was 5/5 throughout. Unofficial x-rays of the lumbar spine performed on unspecified dates reportedly showed a grade 1 spondylolisthesis at L5-S1 with 6 mm of anterolisthesis. He was diagnosed with spondylolisthesis at the L5-S1 and bilateral lower extremity radiculopathy in the L5-S1 nerve root distribution, disc herniation and foraminal stenosis at the L5-S1, and a left knee injury consequence to the lower extremity radiculopathy. The Request for Authorization form was signed on 02/24/2014. The rationale for treatment was not provided.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**One Anterior posterior fusion and Decompression L5-S1: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines- Indication for surgery discectomy

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 307. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back, Fusion.

**Decision rationale:** The California MTUS/ACOEM Guidelines state that those with increased spinal instability after surgical decompression at the level of degenerative spondylolisthesis may be candidates for a fusion. The Official Disability Guidelines state that fusions should not be considered within the first 6 months of symptoms. There should also be evidence that the patient has undergone a psychological evaluation and evidence of instability on imaging studies. While it is understood that the injured worker is symptomatic regarding the lumbar spine, there is a lack of documentation showing that he has undergone all conservative treatment options to support the request for a surgical intervention. There is also no documentation showing that the injured worker has undergone a psychological evaluation clearing him for surgery. In addition, the official x-rays showing spondylolisthesis and documentation of instability on imaging studies was not provided for review. In the absence of this information, the request would not be supported by the evidence based guidelines. As such, the request is not medically necessary.

**Inpatient Stay (2-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.

**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 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.

**Vascular surgeon: 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.

**Internal Medicine 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.

**Off the Shelf Lumbar 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.

**Post Operative Physical Therapy (24-sessions):** 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.

**3-in-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.

**Hospital Bed Rental (30-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.

**One Home Health/Nursing Evaluation:** 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.

**120gm of Ketoprofen 20%/ ketamine 10% 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.

**Decision rationale:** The California MTUS Guidelines state that topical analgesics are largely experimental in use and are primarily recommended for neuropathic pain when trials of antidepressants and anti convulsants have failed. Topical NSAIDs are indicated for osteoarthritis and tendinitis for the short term treatment of 4-12 weeks. Topical Ketamine is under study and is only recommended for treatment of neuropathic pain in refractory cases in which all primary and secondary treatment has been exhausted. There is a lack of documentation showing that the

injured worker had failed all primary and secondary treatment options to support the request for a topical analgesic containing ketamine. There is also no evidence showing that he had a diagnosis of osteoarthritis or tendinitis to support the request for a topical cream containing ketoprofen. In addition, the requesting physician failed to provide the frequency and quantity of the medication within the request and, therefore, the request will not be supported. Given the above, the request is not medically necessary.

**120gm of Flurbiprofen 20% 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): 111-114.

**Decision rationale:** The California MTUS Guidelines state that topical analgesic are largely experimental in use and are primarily recommended for neuropathic pain when trials of antidepressants and anti convulsants have failed. Topical NSAIDs are indicated for osteoarthritis and tendinitis for the short-term treatment of 4-12 weeks. There is no documentation showing that the injured worker had a diagnosis of osteoarthritis or tendinitis to support the request for a topical NSAID. In addition, the requesting physician failed to mention the quantity and frequency of the medication within the request. In the absence of this information, the request would not be supported by the evidence-based guidelines. As such, the request is not medically necessary.

**Soma 350mg, #60: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 299,Chronic Pain Treatment Guidelines Muscle Relaxants.

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

**Decision rationale:** The California MTUS Guidelines state that Soma is not recommended and is not indicated for long term use. It is unclear how long the injured worker has been using this medication, and without this information, a continuation will not be supported as this medication is not recommended for long term use. In addition, the requesting physician failed to mention the frequency of the medication within the request and without this information, the request would not be supported. Given the above, the request is not medically necessary.

**Ultracet 37.5/325mg, #60: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 308,Chronic Pain Treatment Guidelines Opioids.

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

**Decision rationale:** The California MTUS Guidelines state that an ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects should be performed during opioid therapy. There is a lack of documentation showing that the injured worker had been screened for aberrant drug taking behaviors or intolerable side effects to the medication to support continued use. In addition, documentation regarding a quantitative decrease in pain and an objective improvement in function with the use of this medication was not provided. Furthermore, the requesting physician failed to mention the frequency of the medication within the request and without this information, the request will not be supported. Given the above, the request is not medically necessary.