MAXIMUS Federal Services

Case Number:	CM15-0109230		
Date Assigned:	06/18/2015	Date of Injury:	06/26/2003
Decision Date:	07/22/2015	UR Denial Date:	05/13/2015
Priority:	Standard	Application Received:	06/05/2015

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: New York
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 45 year old male who sustained an industrial injury on 6/26/03. In 2001 he had a twisting injury resulting in back injury. In 2003 he had a microdiskectomy because of sharp low back pain. Prior to the surgery he had a series of epidural injections. The surgery offered three months of relief. He since had had severe low back and right leg pain. He currently complains of low back pain. Diagnoses include lumbar disc degeneration; lower extremity pain; chronic leg pain; lumbago; lumbar herniated nucleus pulposus. Diagnostics include MRI lumbar spine (11/12/13) showing two areas of narrowing, diffuse disk protrusion; x-ray of lumbar spine (no date) showed evidence of severe degenerative disk disease. In the progress note dated 2/9/15 the treating provider's plan of care includes requests for Prilisec; Tylenol # 4; gaba/ Flur Compound; Ambien; electrodiagnostic testing in the lower extremities to assess for radiculopathy versus neuropathy; posterior spinal fusion L5-S1; anterior lumbar interbody fusion L5-S1; partial discectomy L5-S1 on the right; transcutaneous electrical nerve stimulator unit for home use; urine test to monitor prescribed medications; length of stay.

IMR ISSUES, DECISIONS AND RATIONALES

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

Prilosec 20mg (quantity unspecified): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS, GI Symptoms & cardiovascular risk Page(s): 58-69.

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

Decision rationale: The California MTUS guidelines do recommend proton pump inhibitors if the patient is at risk for a gastrointestinal even such as history of a peptic ulcer. A proton pump inhibitor would also be recommended if the patient is at high risk of gastrointestinal even with cardiovascular disease. Documentation does not show this history. Therefore, the request for Prilosec 20mg (quantity unspecified) is not medically necessary and appropriate.

Posterior Spinal Fusion L5-S1, ALIF L5-S1 partial discectomy L5-S1 right: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305 and 307.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-7.

Decision rationale: The California MTUS guidelines do recommend a spinal fusion for traumatic vertebral fracture, dislocation and instability. This patient has not had any of these events. The guidelines note that the efficacy of fusion in the absence of instability has not been proven. Therefore, the request for posterior spinal fusion L5-S1, ALIF L5-S1 partial discectomy L5-S1 right is not medically necessary and appropriate.

Tylenol #4 (quantity unspecified): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use Page(s): 76-80 and 82.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for use of opiods-Codeine Page(s): 92.

Decision rationale: The California MTUS guidelines recommend a maximum daily dose of Codeine of 360 mg/ml. Tylenol # 4 contains acetaminophen and codeine. This request does not include the frequency directions or limitations per guidelines. Therefore, this request for Tylenol #4 (quantity unspecified) is not medically necessary and appropriate.

Gaba/Flur Compound (strength & quantity unspecified): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Specific anti-epilepsy drugs-Gabapentin Page(s): 18,19.

Decision rationale: The California MTUS guidelines not that Gabapentin has been shown to be effective in the treatment of diabetic painful neuropathy. It has been recommended as a trial in chronic neuropathic pain associated with spinal cord injury. The guidelines do not recommend its use as a compound. The guidelines note there is no peer-reviewed literature to support its use. Therefore, this request for Gaba/Flur Compound (strength & quantity unspecified) is not medically necessary and appropriate.

Ambien 5mg (quantity unspecified): 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); Treatment Index, 13th Edition (web), 2015, pain procedure.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Medications-Insomnia treatment-Zolpidem.

Decision rationale: The ODG guidelines recommend Zolpidem (Ambien) for short term treatment of insomnia. The requested treatment does not include dosing recommendations. It does not include recommended termination time. Therefore, this request for Ambien 5mg (quantity unspecified) is not medically necessary and appropriate.

Associated surgical service: TENS unit (duration & frequency unspecified): 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.

Associated surgical service: Urine Test: 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.

Associated surgical service: Length of Stay (LOS) (duration unspecified): 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.