

<b>Case Number:</b>	CM15-0136396		
<b>Date Assigned:</b>	07/24/2015	<b>Date of Injury:</b>	08/15/2007
<b>Decision Date:</b>	09/09/2015	<b>UR Denial Date:</b>	06/15/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/14/2015

### 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: California

Certification(s)/Specialty: Physical Medicine & Rehabilitation

### 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 59 year old male with an industrial injury dated 08/15/2007. His diagnoses included lumbar spine radiculitis and lumbar spine disc injury. Prior treatment included medications, diagnostics, conservative treatment and surgery. He presented on 03-02-2015 "almost" one year post lumbar surgery. He had persistent back pain with bilateral lower extremity radiation rated as 8 out of 10. Surgery was requested along with associated surgical services, post-operative physical therapy and transportation. He presented on 03-06-2015 with continued low back pain, worsening of left leg pain, severe burning sensation and "uncontrolled tapping of his left foot". Physical exam noted tenderness to the lumbar spine. Range of motion was limited with pain. Straight leg raising was positive. Weakness was noted to right ankle. On 05/07/2015 hemilaminotomy with decompression of bilateral lumbar 4-5 and left lumbar 5-sacral 1 with revision decompression and microforaminotomy was performed. He presented on 05/18/2015 for follow up. A custom lumbar brace was recommended. The treatment request for x-ray of the lumbar spine with AP/lateral views was authorized. The following requests are for review: Transportation services to and from office visits, Physical therapy x 3 months and Prospective usage of Percocet 10/325 mg #90.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Transportation services to and from office visits: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines -Knee and Leg.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee chapter under Transportation (to & from appointments) and Other Medical Treatment Guidelines [www.aetna.com](http://www.aetna.com) : transportation.

**Decision rationale:** The patient presents with lower back and left leg pain. The request is for transportation services to and from office visits. The request for authorization is not provided. The patient is status post hemilaminotomy with decompression of bilateral L4-5 and left L5-S1 with revision decompression and microforaminotomy, 05/07/15. CT of the lumbar spine, 02/19/15, shows postsurgical changes at L5-S1 with better fusion since the prior study; metallic hardware intact; grade I spondylolisthesis at L4-L5 is again noted; levoscoliosis. Physical examination of the lumbar spine reveals muscle spasms are palpable next to the spinous processes. Range of motion is limited due to pain in the lumbosacral region. Patient has diminished sensation to light touch and pinprick over the lateral calf bilaterally. Straight leg raise positive bilaterally left greater than right. Per progress report dated 06/17/15, the patient is temporarily totally disabled. ODG-TWC guidelines, Knee chapter under Transportation (to & from appointments) states: "Recommended for medically-necessary transportation to appointments in the same community for patients with disabilities preventing them from self-transport (CMS, 2009)." [www.████████.com](http://www.████████.com) : transportation. ██████████ has the following guidelines on transportation: "The cost of transportation primarily for and essential to, medical care is an eligible medical expense. The request must be submitted for reimbursement and the request should document that patient cannot travel alone and requires assistance of a nurse or companion." Treater does not discuss the request. In this case, there is no mention that the patient has disabilities preventing him from self-transport. Treater does not discuss or document the patient's social situation. It is not clear why a friend or a family member cannot drive the patient to the office visits. Additionally, the medical reports do not indicate nursing home level care. Therefore, the request is not medically necessary.

**Physical therapy x 3 months: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Postsurgical Treatment Guidelines  
Page(s): 25, 26.

**Decision rationale:** The patient presents with lower back and left leg pain. The request is for physical therapy x 3 months. The request for authorization is not provided. The patient is status post hemilaminotomy with decompression of bilateral L4-5 and left L5-S1 with revision decompression and microforaminotomy, 05/07/15. CT of the lumbar spine, 02/19/15, shows

postsurgical changes at L5-S1 with better fusion since the prior study; metallic hardware intact; grade I spondylolisthesis at L4-L5 is again noted; levoscoliosis. Physical examination of the lumbar spine reveals muscle spasms are palpable next to the spinous processes. Range of motion is limited due to pain in the lumbosacral region. Patient has diminished sensation to light touch and pinprick over the lateral calf bilaterally. Straight leg raise positive bilaterally left greater than right. Per progress report dated 06/17/15, the patient is temporarily totally disabled. MTUS post-surgical guidelines pages 25, 26 recommends for Intervertebral disc disorders without myelopathy, Postsurgical treatment (discectomy/laminectomy): 16 visits over 8 weeks. Postsurgical physical medicine treatment period: 6 months ODG-TWC Guidelines, under Physical therapy (PT) Section states, "Recommended. There is strong evidence that physical methods, including exercise and return to normal activities, have the best long-term outcome in employees with low back pain. Post-surgical treatment (discectomy/laminectomy): 16 visits over 8 weeks." Treater does not discuss the request. In this case the patient is status post hemilaminotomy with decompression surgery. Guidelines allow up to 16 visits over 8 weeks of post-surgical physical therapy treatments. However, the request for unspecified number of visits over 3 months of post-op physical therapy exceeds what is recommended by ODG guidelines. Therefore, the request is not medically necessary.

#### **Prospective usage of Percocet 10/325mg #90: Overturned**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, specific drug list.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Medications for chronic pain CRITERIA FOR USE OF OPIOIDS Page(s): 60, 61, 76-78, 88, 89, 80, 81.

**Decision rationale:** The patient presents with lower back and left leg pain. The request is for prospective usage of percocet 10/325MG #90. The request for authorization is not provided. The patient is status post hemilaminotomy with decompression of bilateral L4-5 and left L5-S1 with revision decompression and microforaminotomy, 05/07/15. CT of the lumbar spine, 02/19/15, shows postsurgical changes at L5-S1 with better fusion since the prior study; metallic hardware intact; grade I spondylolisthesis at L4-L5 is again noted; levoscoliosis. Physical examination of the lumbar spine reveals muscle spasms are palpable next to the spinous processes. Range of motion is limited due to pain in the lumbosacral region. Patient has diminished sensation to light touch and pinprick over the lateral calf bilaterally. Straight leg raise positive bilaterally left greater than right. Per progress report dated 06/17/15, the patient is temporarily totally disabled. MTUS Guidelines pages 88 and 89 states, "Pain should be assessed at each visit, and functioning should be measured at 6-month intervals using a numerical scale or validated instrument." MTUS page 78 also requires documentation of the 4As -analgesia, ADLs, adverse side effects, and adverse behavior-, as well as "pain assessment" or outcome measures that include current pain, average pain, least pain, intensity of pain after taking the opioid, time it takes for medication to work and duration of pain relief. Pages 80, 81 of MTUS also states "There are virtually no studies of opioids for treatment of chronic lumbar root pain with resultant radiculopathy," and for chronic back pain, it "Appears to be efficacious but limited for short-term pain relief, and long-term efficacy is unclear (>16 weeks), but also appears limited." Treater does

not specifically discuss this medication. This appears to be the initial trial prescription of Percocet. Review of provided medical records show no evidence of prior prescription of Percocet. Since this is the initial trial, the treater has not had the opportunity to document the efficacy of this medication. Therefore, the request is medically necessary.