

<b>Case Number:</b>	CM15-0146420		
<b>Date Assigned:</b>	08/10/2015	<b>Date of Injury:</b>	04/08/2011
<b>Decision Date:</b>	09/28/2015	<b>UR Denial Date:</b>	07/20/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/28/2015

### 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, Indiana, Oregon  
 Certification(s)/Specialty: Orthopedic 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 44 year old female, who sustained an industrial injury on April 8, 2011. She reported she heard a pop in her back and experienced difficulty rising and straightening upright. The injured worker was diagnosed as having a sprain-strain. Treatment to date has included MRI, medication, surgery, activity modification, physical therapy, electrodiagnostic study, toxicology screens, lumbar epidural injection, pain management and assistive device (walker). Currently, the injured worker complains of lumbar spine pain that radiates to her hips and down both of her legs and toes. The pain is associated with numbness, tingling, cramping, burning, throbbing, stabbing, electrical shock, aching, dull and sharp sensations coupled with stiffness, locking, giving way, popping and weakness. She reports limited range of motion and difficulty with bending, reaching, rotation, stooping, lifting, pushing, pulling, carrying, climbing, running, walking, standing, sitting, twisting, turning, leaning, laying down, squatting and kneeling. Her pain is rated at 8 on 10. She also reports difficulty engaging activities of daily living and functioning as well as a sleep disturbance due to the pain. The injured worker is currently diagnosed with post laminectomy syndrome, lumbar radiculopathy, stenosis, scoliosis and spinal instability with neurologic deficits. Her work status is temporary total disability. A noted dated February 5, 2015, states the injured worker experienced increased pain from physical therapy, she did; however, experience low back efficacy from traction. A note dated May 11, 2015, states the injured worker experienced temporary relief from the epidural injection. The note also states she experienced some benefit from surgical intervention. It also states the injured worker was unable to tolerate stronger pain medication as she was unable to

function at work. Due to continued pain the following; Transforaminal lumbar interbody fusion PSF-PSI at L3-S1, post-op physical therapy 3x6, Valium 5 mg #100, Percocet 10-325 mg #100, Associated surgical services-surgical assistant, inpatient hospital stay 3x 3 days, external bone growth stimulator, lumbar brace, island bandage x 1 box, are requested.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

#### **Transforaminal lumbar interbody fusion, PSF/PSI at L3-S1: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

**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.

**Decision rationale:** The ACOEM Guidelines Chapter 12 Low Back Complaints page 307 state that lumbar fusion, "Except for cases of trauma-related spinal fracture or dislocation, fusion of the spine is not usually considered during the first three months of symptoms. Patients with increased spinal instability (not work-related) after surgical decompression at the level of degenerative spondylolisthesis may be candidates for fusion." According to the ODG, Low back, Fusion (spinal) should be considered for 6 months of symptoms. Indications for fusion include neural arch defect, segmental instability with movement of more than 4.5 mm, revision surgery where functional gains are anticipated, infection, tumor, deformity and after a third disc herniation. In addition, ODG states, there is a lack of support for fusion for mechanical low back pain for subjects with failure to participate effectively in active rehab pre-op, total disability over 6 months, active psych diagnosis, and narcotic dependence. In this particular patient there is lack of medical necessity for lumbar fusion as there is no evidence of segmental instability greater than 4.5 mm to warrant fusion. Therefore the request is not medically necessary.

#### **Associated surgical service: Surgical assistant: 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: Inpatient hospital stay x 3 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.

**Associated surgical service: External bone growth stimulator:** 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: 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.

**Associated surgical service: Island bandage x 1 box:** 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-op physical therapy 3 x 6:** 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.

**Diazepam 5mg #100:** 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 Benzodiazepines Page(s): 24.

**Decision rationale:** According to the CA Chronic Pain Medical Treatment Guidelines, page 24, Benzodiazepines are not recommended for long-term use because long-term efficacy is unproven and there is a risk of dependence. Most guidelines limit use to 4 weeks. Their range of action includes sedative/hypnotic, anxiolytic, anticonvulsant, and muscle relaxant. Chronic benzodiazepines are the treatment of choice in very few conditions. Tolerance to hypnotic effects develops rapidly. Tolerance to anxiolytic effects occurs within months and long-term use may actually increase anxiety. A more appropriate treatment for anxiety disorder is an antidepressant. Tolerance to anticonvulsant and muscle relaxant effects occurs within weeks. In this case there is no rationale from the exam notes of why Valium is required. Therefore the request for Valium is not medically necessary.

**Percocet 10/325mg #100:** 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): 80.

**Decision rationale:** According to the CA MTUS/Chronic Pain Medical Treatment Guidelines, page 80, opioids should be continued if the patient has returned to work and the patient has improved functioning and pain. Based upon the records reviewed there is insufficient evidence to support chronic use of narcotics. In this case, there is lack of demonstrated functional improvement, percentage of relief, demonstration of urine toxicology compliance or increase in activity due to medications. Therefore the request is not medically necessary.