

Case Number:	CM15-0162590		
Date Assigned:	08/28/2015	Date of Injury:	04/14/2011
Decision Date:	10/05/2015	UR Denial Date:	07/24/2015
Priority:	Standard	Application Received:	08/19/2015

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: Illinois, California, Texas
 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:

This injured worker is a 39-year-old male who sustained an industrial injury on 4/14/11. Injury occurred when he slipped and fell while working as a machine operator, and landed on his back. Past medical and surgical history was negative. The 5/6/15 pain management report indicated that the injured worker was prescribed omeprazole for medication-induced gastritis and tramadol for pain. He was hesitant to take medications due to his gastritis response. The 6/26/15 urine drug screen was negative for any tested medications. The 7/2/15 treating physician report cited significant back pain radiating towards his left leg. The injured worker had difficulty walking with an obvious limp. He was using a cane to support his weight. He required help to transition from sit to stand. Neurologic exam documented 4/5 left dorsiflexion, extensor hallucis longus and plantar flexion weakness. The diagnosis was lumbar radiculopathy. The 6/29/15 thoracic and lumbar spine MRI was reviewed and demonstrated multilevel thoracic disc desiccation and L5/S1 degenerative disc disease. There was no significant central canal stenosis, however there was foraminal stenosis at L5/S1, left greater than right. Review of the 2013 electrodiagnostic study showed evidence of bilateral left greater than right L5 radiculopathies. The injured worker had bilateral lumbar radiculopathy at L5 with foraminal stenosis at the L5/S1 level, left greater than right. He had failed a considerable amount of conservative treatment, including pain management, medications, home exercise, physical therapy, chiropractic therapy, and injections. There was nerve root dysfunction evidence on the exam confirmed by EMG and MRI. The injured worker was felt to be psychologically prepared for surgery. Authorization was requested for L5/S1 anterior laminectomy, bilateral facetectomy and transforaminal lumbar interbody

fusion supplemented by pedicle screws with inpatient stay x 1-2 days, Colace 100mg #60 4, random urine drug screen, MRI of the lumbar spine, Norco 5/325mg #60, post-operative physical therapy 2 x 12, pre-operative medical clearance, and omeprazole 20mg #60. The 7/24/15 utilization review non-certified the L5/S1 anterior laminectomy, bilateral facetectomy and transforaminal lumbar interbody fusion supplemented by pedicle screws and associated surgical requests as there was no formal imaging for review demonstrating segmental motion or motion instability at the L5/S1 level to support the medical necessity of fusion.

IMR ISSUES, DECISIONS AND RATIONALES

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

L5-S1 Anterior laminectomy, bilateral facetectomy and transforaminal lumbar interbody fusion supplemented by pedicle screws: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-307. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back, Lumbar & Thoracic, Discectomy/Laminectomy, Fusion (spinal).

Decision rationale: The California MTUS recommend surgical consideration when there is severe and disabling lower leg symptoms in a distribution consistent with abnormalities on imaging studies (radiculopathy), preferably with accompanying objective signs of neural compromise. Guidelines require clear clinical, imaging and electrophysiologic evidence of a lesion that has been shown to benefit both in the short term and long term from surgical repair. The guidelines recommend that clinicians consider referral for psychological screening to improve surgical outcomes. The Official Disability Guidelines recommend criteria for lumbar discectomy that include symptoms/findings that confirm the presence of radiculopathy and correlate with clinical exam and imaging findings. Guideline criteria include evidence of nerve root compression, imaging findings of nerve root compression, lateral disc rupture, or lateral recess stenosis, and completion of comprehensive conservative treatment. The Official Disability Guidelines do not recommend lumbar fusion for patients with degenerative disc disease, disc herniation, spinal stenosis without degenerative spondylolisthesis or instability, or non-specific low back pain. Fusion may be supported for segmental instability (objectively demonstrable) including excessive motion, as in isthmic or degenerative spondylolisthesis, surgically induced segmental instability and mechanical intervertebral collapse of the motion segment and advanced degenerative changes after surgical discectomy. Spinal instability criteria includes lumbar inter-segmental translational movement of more than 4.5 mm. Pre-operative clinical surgical indications require completion of all physical therapy and manual therapy interventions, x-rays demonstrating spinal instability and/or imaging demonstrating nerve root impingement correlated with symptoms and exam findings, spine fusion to be performed at 1 or 2 levels, psychosocial screening with confounding issues addressed, and smoking cessation for at least 6 weeks prior to surgery and during the period of fusion healing. Guideline criteria have not been met. This injured worker presents with persistent back pain radiating to the left leg with significant functional difficulty precluding return to work. Clinical exam findings are consistent

with reported imaging and electrodiagnostic evidence of nerve root compromise at the L5/S1 level. Detailed evidence of a recent, reasonable and/or comprehensive non-operative treatment protocol trial and failure has been submitted. Psychosocial screening was documented. However, there is no radiographic evidence of spondylolisthesis or spinal segmental instability on flexion and extension x-rays consistent with guideline criteria to support fusion. There is no discussion or imaging evidence supporting the need for wide decompression that would result in temporary intraoperative instability and necessitate fusion. Therefore, this request is not medically necessary at this time.

Associated surgical service: Inpatient stay x 1-2 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: As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate. This review presumes that a surgery is planned and will proceed. There is no medical necessity for this request if the surgery does not occur.

Colace 100mg #60: 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: As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate. This review presumes that a surgery is planned and will proceed. There is no medical necessity for this request if the surgery does not occur.

Associated surgical service: Random urine drug screen: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Urine Drug Screen Page(s): 43.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids-Criteria for use Page(s): 43 and 76-80. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain (Chronic), Urine drug testing (UDT).

Decision rationale: The California MTUS supports the use of urine drug screening in patients using opioid medication with issues of abuse, addiction, or poor pain control. The Official Disability Guidelines support on-going monitoring if the patient has evidence of high risk of addiction, history of aberrant behavior, history of addiction, or for evaluation of medication

compliance and adherence. Random testing no more than twice a year is recommended for patients considered at low risk for adverse events or drug misuse. Those patients at intermediate risk are recommended to have random testing 3 to 4 times a year. Patients at high risk for adverse events/misuse may at a frequency of every other and even every visit. Guideline criteria have not been met. A urine drug testing was performed on 6/26/15. There is no compelling rationale presented to support the medical necessity of a repeat urine drug screen at this time. Therefore, this request is not medically necessary.

Associated surgical service: MRI of the lumbar spine: 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: As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate. This review presumes that a surgery is planned and will proceed. There is no medical necessity for this request if the surgery does not occur.

Norco 5/325mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 78-81.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 308, Chronic Pain Treatment Guidelines Opioids, criteria for use, Hydrocodone/acetaminophen Page(s): 76-80 and 91.

Decision rationale: The California Medical Treatment Utilization Schedule guidelines support the use of opioids on a short term basis for back pain. Guidelines recommend Norco for moderate to moderately severe pain on an as needed basis with a maximum dose of 8 tablets per day. Short-acting opioids, also known as normal-release or immediate-release opioids, are seen as an effective method in controlling both acute and chronic pain. The use of this medication would be supported as prescribed by the surgeon in the post-operative period. However, the associated surgical request is not supported. Guidelines state that opioid medication management requires prescriptions from a single practitioner taken as directed. Records indicate that the pain management physician has been provided medication management. Additional prescriptions outside the post-surgical period by another physician would not be consistent with guidelines. Therefore, this request is not medically necessary.

Post-operative physical therapy 2 x 12: 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: As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate. This review presumes that a surgery is planned and will proceed. There is no medical necessity for this request if the surgery does not occur.

Pre-operative medical 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: As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate. This review presumes that a surgery is planned and will proceed. There is no medical necessity for this request if the surgery does not occur.

Omeprazole 20mg #60: 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: As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate. This review presumes that a surgery is planned and will proceed. There is no medical necessity for this request if the surgery does not occur.