

<b>Case Number:</b>	CM15-0165179		
<b>Date Assigned:</b>	09/03/2015	<b>Date of Injury:</b>	08/31/2011
<b>Decision Date:</b>	10/23/2015	<b>UR Denial Date:</b>	08/04/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/24/2015

### 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: 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 37 year old male smoker, who sustained an industrial injury on 8-31-2011. The mechanism of injury is not described. The current diagnoses are L5-S1 herniated nucleus pulposus with annular tear. According to the progress report dated 7-20-2015, the injured worker complains of severe low back pain with radiation into the right lower extremity. The pain is described as aching and stabbing with numbness and pins and needles sensation. The pain is rated 10 out of 10 on a subjective pain scale. The physical examination of the lumbar spine reveals antalgic gait, significant tenderness in the paralumbar musculature, positive sciatic stretch and straight leg raise on the right, significantly reduced range of motion, paraspinous muscle spasms on the right, slight diminution of ankle jerk reflex on the right, decreased plantar strength on the right, and diminished posterolateral foot and heel sensation on the right. The current medications are Norco. Urine drug screen from 7-20-2015 is inconsistent with prescribed medications, Hydrocodone was not detected. Treatment to date has included medication management, physical therapy, pain injection, and discogram. Discogram from 5-12-2015 shows positive L5-S1 discogram with severe immediate concordant low back pain associated with moderate disc degeneration and contained posterior annular defect. Work status is described as temporarily totally disabled. A request for L5-S1 transforaminal lumbar interbody fusion with posterior spinal fusion and pedicle screws with associated surgical services has been submitted.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**L5-S1 transforaminal lumbar interbody fusion with posterior spinal fusion and pedicle screws:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Low Back Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back, Hardware.

**MAXIMUS guideline:** Decision based on MTUS Low Back Complaints 2004, Section(s): Surgical Considerations. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low back, Fusion.

**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 symptom. 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, severe stenosis or psychiatric clearance from the exam note of 7/20/15 to warrant fusion. In addition, there is lack of evidence of smoking cessation to warrant fusion. Therefore, the determination is not medically necessary for lumbar fusion.

**Two day inpatient hospital stay:** 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), Low Back, Hospital length of stay.

**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, Hospital length of stay.

**Decision rationale:** As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.

**Preoperative clearance:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation [www.guideline.gov/content.aspx?id=48408](http://www.guideline.gov/content.aspx?id=48408);

Perioperative protocol. Health care protocol. Bibliographic Source(s) Card R, Sawyer M, Degnan B, Harder K, Kemper J, Marshall M, Matteson M, Roemer R, Schuller-Debus G, Swanson C, Stultz J, Sypura W, Terrell C, Varela N. Perioperative protocol. Health care protocol. Bloomington (MN): Institute for Clinical Systems Improvement (ICSI); 2014 Mr. 124p [124 references].

**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, Preoperative testing.

**Decision rationale:** As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.

**Associated Surgical Service: One time psychological clearance:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Office visits.

**Decision rationale:** As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.

**Post-operative physical therapy for the lumbar spine, twice a week for four weeks:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Postsurgical Treatment 2009.

**MAXIMUS guideline:** Decision based on MTUS Postsurgical Treatment 2009, Section(s): Low Back.

**Decision rationale:** As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.

**Post-operative evaluation by an RN:** 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), Low Back, Home health services.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Home health services.

**Decision rationale:** As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.

**Associated Surgical Service: Home help with frequency and duration determined post operatively:** 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), Low Back, Home health services.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Home health services.

**Decision rationale:** As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.

**Associated Surgical Service: Bone growth stimulator:** 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), Low Back, Bone growth stimulators.

**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, bone growth stimulator.

**Decision rationale:** As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.

**Associated Surgical Service: Front wheel walker:** 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), Knee & Leg, Walking aids (canes, crutches, braces, orthoses, & walkers).

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee and Leg, Walking aids.

**Decision rationale:** As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.

**Associated Surgical Service: Ice unit:** 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), Low Back, Cold/heat packs.

**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, Continuous flow cryotherapy.

**Decision rationale:** As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.

**Associated Surgical Service: Lumbar spine orthosis:** 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), Low Back, Back brace, post operative (fusion).

**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, Brace postoperative.

**Decision rationale:** As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.

**Associated Surgical Service: 3 in 1 commode:** 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), Knee & 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 and Leg, DME toilet items.

**Decision rationale:** As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.

**Flurbiprofen, Diclofenac, Gabapentin, Lidocaine cream, supply 1-2 grams 1-2 times daily:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Topical Analgesics.

**Decision rationale:** Per the CA MTUS regarding topical analgesics, Chronic Pain Medical Treatment Guidelines, Topical analgesics, page 111-112 "Largely experimental in use with few randomized controlled trials to determine efficacy or safety. Primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. There is little to

no research to support the use of many of these agents. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended." Therefore the determination is for not medically necessary.

**Zofran 8mg #10, 1 tablet every 8 hours PRN: 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), Pain, Anti-emetics (for opioid nausea).

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Ondansetron.

**Decision rationale:** CA MTUS/ACOEM is silent on the issue of Zofran for postoperative use. According to the ODG, Pain Chapter, Ondansetron (Zofran) is not recommended for nausea and vomiting secondary to chronic opioid use. In this case, the exam note from 7/20/15 does not demonstrate evidence of nausea and vomiting or increased risk for postoperative issues. Therefore determination is for not medically necessary.

**Duracef 500mg 1 tablet BID for 7 days: 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), Infectious Diseases, Cefadroxil (Duricef).

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Infectious Disease Chapter, Cefadroxil.

**Decision rationale:** CA MTUS/ACOEM is silent on the issue of Duracef. According to the ODG, Infectious Disease Chapter, "Cefadroxil (Duracef) is recommended as first line treatment for infections." In this case, the records submitted do not demonstrate any evidence of active infection. Therefore the determination is for not medically necessary.