

<b>Case Number:</b>	CM15-0190444		
<b>Date Assigned:</b>	10/13/2015	<b>Date of Injury:</b>	07/18/2014
<b>Decision Date:</b>	11/24/2015	<b>UR Denial Date:</b>	09/21/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/28/2015

### **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: New York, Montana, California  
 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:

This 43 year old man sustained an industrial injury on 7-18-2014. Evaluations include lumbar spine x-rays dated 3-16-2015 and lumbar spine MRI dated 4-9-2015. Diagnoses include lumbosacral herniated nucleus pulposus, status post lumbar surgery with residual-recurrent herniated nucleus pulposus, and post-laminectomy instability. Treatment has included oral medications, physical therapy, and epidural steroid injections. Physician notes dated 9-16-2015 show complaints of low back pain with radiation to the right lower extremity with spasms and headaches since a spinal injection last month. The worker rates his pain 9 out of 10 without medications and 7 out of 10 with medications. The physical examination shows normal reflex, sensory, and motor testing of the bilateral upper and lower extremities with the exception of decreased strength, sensation, and reflex in the right S1 dermatome. Straight leg raise and bowstring are positive on the right, an antalgic gait is noted, inability to toe walk, lumbar tenderness with muscle spasms in the paraspinal musculature, and "lumbar spine range of motion is decreased about 50%" without measurements. Recommendations include further surgical intervention, post-operative lumbar sacral orthotic brace, polar care unit, muscle stimulator, bone stimulator, emergency blood patch, urine drug screen, Naproxen, Pantoprazole, Tramadol, Percocet, and follow up in one month. Utilization Review denied requests for anterior lumbar discectomy and fusion including lateral retroperitoneal approach of L5-S1, remove vertebral body of L5-S1, anterior lumbar arthrodesis including discectomy, application of cage, application of plate, allograft, radiologic examination of the lumbosacral spine, inpatient hospital days, assistant surgeon, medical clearance, bone growth stimulator, interferential unit,

lumbosacral orthotic brace, co-surgeon, shower chair, raised toilet seat, hip skirt, hot-cold therapy unit, post-operative physical therapy, Percocet, and Ultram on 9-21-2015.

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

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

**ALDF with allograft, cage and plate, L5-S1: 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, Fusion (spinal).

**MAXIMUS guideline:** Decision based on MTUS Low Back Complaints 2004, Section(s): Surgical Considerations.

**Decision rationale:** The California MTUS guidelines do recommend lumbar surgery if there is clear clinical, electrophysiological and imaging evidence of specific nerve root or spinal cord level of impingement which would correlate with severe, persistent debilitating lower extremity pain unresponsive to conservative management. Documentation does not provide this evidence. California MTUS guidelines do recommend spinal fusion for fracture, dislocation and instability. Documentation does not provide evidence of this. His magnetic resonance imaging scan (MRI) showed no severe canal or foraminal stenosis or nerve root impingement, or disc herniation. His provider recommended an anterior lateral lumbar arthrodesis L5-S1 with allograft, cage and plate to treat his lumbago. Documentation does not present evidence of instability or radiculopathy. According to the Guidelines for the performance of fusion procedures for degenerative diseases of the lumbar spine, published by the joint section of the American Association of Neurological surgeons and Congress of Neurological surgeons in 2005 there was no convincing medical evidence to support the routine use of lumbar fusion at the time of primary lumbar disc excision. This recommendation was not changed in the update of 2014. The update did note that fusion might be an option if there is evidence of spinal instability, chronic low back pain and severe degenerative changes. Documentation does not show instability or severe degenerative changes. The requested treatment: ALDF with allograft, cage and plate, L5-S1 is not medically necessary and appropriate

**Anterior lumbar arthrodesis including discectomy, including lateral retroperitoneal approach technique: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Low Back Complaints 2004, Section(s): Surgical Considerations.

**MAXIMUS guideline:** Decision based on MTUS Low Back Complaints 2004, Section(s): Surgical Considerations.

**Decision rationale:** The California MTUS guidelines do recommend lumbar surgery if there is clear clinical, electrophysiological and imaging evidence of specific nerve root or spinal cord level of impingement which would correlate with severe, persistent debilitating lower extremity

pain unresponsive to conservative management. Documentation does not provide this evidence. California MTUS guidelines do recommend spinal fusion for fracture, dislocation and instability. Documentation does not provide evidence of this. His magnetic resonance imaging scan (MRI) showed no severe canal or foraminal stenosis or nerve root impingement, or disc herniation. His provider recommended an anterior lumbar arthrodesis L5-S1, including discectomy, retroperitoneal approach to treat his lumbago. Documentation does not present evidence of instability or radiculopathy. According to the Guidelines for the performance of fusion procedures for degenerative diseases of the lumbar spine, published by the joint section of the American Association of Neurological surgeons and Congress of Neurological surgeons in 2005 there was no convincing medical evidence to support the routine use of lumbar fusion at the time of primary lumbar disc excision. This recommendation was not changed in the update of 2014. The update did note that fusion might be an option if there is evidence of spinal instability, chronic low back pain and severe degenerative changes. Documentation does not show instability or severe degenerative changes. The requested treatment: Anterior lumbar arthrodesis with discectomy, L5-S1 is not medically necessary and appropriate

**Three day inpatient hospital stay:** 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.

**Assistant surgeon:** 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.

**Associated Surgical Service: 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.

**Associated Surgical Service: Radiologic examination for the lumbosacral 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.

**Associated Surgical Service: Bone growth stimulator for 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.

**Associated Surgical Service: Meds-4 IF unit for 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.

**Associated Surgical Service: LSO back 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:** As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.

**Associated Surgical Service: Shower chair: 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.

**Associated Surgical Service: Raised toilet seat:** 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.

**Associated Surgical Service: Hip kit:** 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.

**Associated Surgical Service: Hot/Cold therapy unit for 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.

**Post operative physical therapy for the lumbar spine twice a week for six weeks:** 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.

**Percocet 10/325mg #90:** Upheld

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

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

**Decision rationale:** The California MTUS guidelines page 92 note that Oxycodone should initially be administered 2.5 to 5 mg every four to 6 hours. The guidelines page 78 further recommend that the lowest possible dose to gain effect should be chosen. In the management of the patient receiving opioids, the guidelines also recommend the patient keep a diary and the provider monitor the patient for physical and psychosocial functionality and side effects. Documentation does not provide this evidence. The requested treatment Percocet 10/325mg #90 is not medically necessary and appropriate.

**Ultram 50 #60:** Upheld

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

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

**Decision rationale:** The California MTUS Chronic Pain Medical Treatment guidelines note Tramadol is not recommended as a first-line oral analgesic. They note the side effects of dizziness, nausea, constipation, headache, somnolence and increased risk of seizures if the patient is taking SSRIs and other opioids. Documentation does not provide evidence the patient is not having side effects. They note the recommended dose should not exceed 400 mg/day. The Guidelines also note as above that the patient be taking two opioid analgesics may increase risk of seizures. Documentation does not outline this admonition. The requested treatment: Ultram 50mg #60 is not medically necessary and appropriate.