

Case Number:	CM15-0216658		
Date Assigned:	11/06/2015	Date of Injury:	10/06/2012
Decision Date:	12/18/2015	UR Denial Date:	11/02/2015
Priority:	Standard	Application Received:	11/03/2015

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 59-year-old male who sustained an industrial injury on 10/6/12. Injury occurred when he was operating a pallet jack and a co-worker driving a fork lift hit the pallet jack. The impact caused him to fall on his knees. The 6/5/13 lumbar spine MRI impression documented straightening of the lumbar spine. There was early disc desiccation noted at the L3/4, L4/5, and L5/S1 levels. At L3/4, there was a diffuse disc protrusion with effacement of the thecal sac and neuroforaminal stenosis that effaced the L3 nerve roots bilaterally. At L4/5, there was a focal central disc protrusion superimposed on a diffuse disc bulge indenting the thecal sac. There was bilateral neuroforaminal stenosis that encroached upon the bilateral L4 exiting nerve roots. At L5/S1, there was a focal disc protrusion superimposed on a diffuse disc bulge effacing the thecal sac. There was bilateral neuroforaminal stenosis that encroached upon the bilateral L5 exiting nerve roots. There grade 1 retrolisthesis of L3 over L4 noted.

Conservative treatment had included physical therapy, chiropractic care, work modifications, and medications. The 8/28/15 pain management consult report cited grade 7/10 low back pain radiating to the bilateral legs down to the calf with numbness and tingling. Physical exam documented antalgic gait, exacerbation of his antalgic gait on the right with heel-toe walk, diffuse lumbar paraspinal tenderness, and moderate L4-S1 facet tenderness. There was mild limitation in lumbar range of motion. Mechanical and nerve tension signs were positive bilaterally. Lower extremity neurologic exam documented decreased L3 and L4 sensation, 4/5 bilateral hip flexor and knee extensor weakness, and diminished patellar reflexes bilaterally. The treatment plan recommended bilateral L3/4 and L5/S1 transforaminal epidural steroid

injections. The injured worker was started on Tramadol ER 150 mg #60, Fexmid 7.6 mg #60, Protonix 20 mg #30, and Motrin 800 mg #60. The 10/2/15 pain management report indicated that the injured worker had previously been prescribed anti-inflammatory and opioid pain medications prior to initiation of Tramadol without sufficient pain relief. Tramadol was opined to be appropriate and reasonable to prevent symptom recurrence that interfered with his function abilities. The 10/20/15 treating physician report indicated that the injured worker presented for follow-up. Physical exam documented paraspinal tenderness to palpation, full lumbar range of motion. Lower extremity neurologic exam documented normal strength, diminished right L5 dermatomal sensation, 2+ reflexes, negative Achilles clonus, and negative straight leg raises. Imaging showed L4 to S1 stenosis. The injured worker was capable of modified work. Authorization was requested for L4- S1 decompression with possible fusion and Tramadol 150 mg #60. The 10/30/15 utilization review denied the request for L4-S1 decompression with possible fusion was non-certified as the injured worker only had back pain with no radicular symptoms, imaging evidence was limited to early mild disc desiccation, there was no evidence of spinal instability, and there was no psychosocial screen. The request for Tramadol 150 mg #60 was non-certified with no stated rationale for non-certification. The 11/10/15 spine surgery appeal for the L4-S1 decompression and fusion indicated that the injured worker had low back pain radiating to the right leg and a neurologic deficit in a concordant dermatome to the foraminal stenosis. Tramadol was being prescribed for flare-up episodes when anti-inflammatories were not sufficient in controlling his pain.

IMR ISSUES, DECISIONS AND RATIONALES

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

Decompression with possible fusion at L4-S1: 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 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 fully met. This injured worker presents with low back pain radiating into the right lower extremity. Functional difficulty presented full duty work. Clinical exam findings were consistent with imaging evidence of nerve root compromise at the L4/5 and L5/S1 levels. Detailed evidence of a recent, reasonable and/or comprehensive non-operative treatment protocol trial and failure has not been submitted. A recent pain management consult had recommended a change in medications and epidural steroid injections with no documentation that this had been completed. There is no radiographic evidence of spondylolisthesis or spinal segmental instability on flexion and extension x-rays. There is no discussion or imaging evidence supporting the need for wide decompression that would result in temporary intraoperative instability and necessitate fusion. There is no evidence of a psychosocial screen. Therefore, this request is not medically necessary at this time.

Tramadol 150mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids for chronic pain.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids, criteria for use, Opioids, specific drug list.

Decision rationale: The California MTUS guidelines support the use of Tramadol for moderate to moderately severe pain. Tramadol is not recommended as a first line oral analgesic. If used on a long-term basis, the criteria for use of opioids should be followed. On-going management requires documentation that the prescriptions are from a single practitioner and are taken as directed; the lowest possible dose is being prescribed; and there will be ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects as criteria necessary to support the medical necessity of this medication. Guideline criteria have not been met. This injured worker presents with low back pain radiating into the bilateral lower extremities. He is currently under the care of a pain management physician who has prescribed Tramadol since 8/28/15 following failed first-line opioid medication. The prescription of this medication by a second physician is not consistent with guidelines that recommend opioid prescriptions should be from a single practitioner. Therefore, this request is not medically necessary.