

<b>Case Number:</b>	CM15-0031311		
<b>Date Assigned:</b>	02/24/2015	<b>Date of Injury:</b>	09/05/2001
<b>Decision Date:</b>	04/14/2015	<b>UR Denial Date:</b>	01/28/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/19/2015

### 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: District of Columbia, Virginia  
Certification(s)/Specialty: Internal Medicine

### 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 72-year-old male injured worker suffered an industrial injury on 9/5/2001. The diagnoses were post laminectomy syndrome and lumbosacral neuritis. The treatments were cervical and lumbar fusion, right knee arthroscopy, spinal cord stimulator, medications, physical therapy, TENS unit, facet joint injections, epidural steroid injections, and massage therapy. The treating provider reported low back pain radiating down her legs and feet 10/10 with tenderness over the lumbar spine with positive straight leg raise. The injured worker has new onset urinary incontinence with an urgent MAGNETIC RESONANCE IMAGING revealed a herniated lumbar disc. The Utilization Review Determination on 1/28/2015 non-certified: 1. Lumbar surgical decompression with lateral interbody spinal fusion, MTUS, ACOEM. 2. Norco 10/325 mg, 120 count, MTUS. 3. Follow up consultation.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Lumbar surgical decompression with lateral interbody spinal fusion:** Overturned

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints  
Page(s): 305-315.

**Decision rationale:** Per ACOEM: Direct methods of nerve root decompression include laminotomy, standard discectomy, and laminectomy. Chemonucleolysis with chymopain is an example of an indirect method. Indirect chemical methods are less efficacious and have rare but serious complications (e.g., anaphylaxis, arachnoiditis). Percutaneous discectomy is not recommended because proof of its effectiveness has not been demonstrated. Recent studies of chemonucleolysis have shown it to be more effective than placebo, and it is less invasive, but less effective, than surgical discectomy; however, few providers are experienced in this procedure because it is not widely used anymore. Surgical discectomy for carefully selected patients with nerve root compression due to lumbar disk prolapse provides faster relief from the acute attack than conservative management; but any positive or negative effects on the lifetime natural history of the underlying disk disease are still unclear. Given the extremely low level of evidence available for artificial disk replacement or percutaneous endoscopic laser discectomy (PELD), it is recommended that these procedures be regarded as experimental at this time. This patient had ongoing issues with back pain and developed signs which were concerning for further neurologic compromise. This would be an indication for surgical decompression.

**Norco 10/325 mg, 120 count:** 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 9792  
Page(s): 75, 91, 124-127.

**Decision rationale:** Per MTUS: Short-acting opioids: also known as "normal-release" or "immediate-release" opioids are seen as an effective method in controlling chronic pain. They are often used for intermittent or breakthrough pain. These agents are often combined with other analgesics such as acetaminophen and aspirin. These adjunct agents may limit the upper range of dosing of shortacting agents due to their adverse effects. The duration of action is generally 3-4 hours. Shortacting opioids include Morphine (Roxanol #130), Oxycodone (OxyIR #130, Oxyfast #130), Endocodone #130, Oxycodone with acetaminophen, (Roxilox #130, Roxicet #130, Percocet #130, Tylox #130, Endocet #130), Hydrocodone with acetaminophen, (Vicodin #130, Lorcet #130, Lortab #130, Zydone #130, Hydrocet #130, Norco #130), Hydromorphone (Dilaudid #130, Hydrostat #130). (Baumann, 2002) Hydrocodone/Acetaminophen (Anexsia #130, Co-Gesic #130, Hycet, Lorcet #130, Lortab #130, Margesic-H #130, Maxidone, Norco #130, Stagesic #130, Vicodin #130, Xodol #130, Zydone #130, generics available): Indicated for moderate to moderately severe pain. Note: there are no FDA-approved hydrocodone products for pain unless formulated as a combination. Side Effects: See opioid adverse effects. Analgesic dose: The usual dose of 5/500mg is 1 or 2 tablets PO every four to six hours as needed for pain (Max 8 tablets/day). For higher doses of hydrocodone (>5mg/tab) and acetaminophen (>500mg/tab) the recommended dose is usually 1 tablet every four to six hours as needed for pain. Hydrocodone has a recommended maximum dose of 60mg/24 hours. The dose is limited by the dosage of acetaminophen, which should not exceed 4g/24 hours. This patient had chronic

pain issues. This medication would be indicated for short term usage. The medication should be weaned. It would not be indicated for long term usage.

**Follow up consultation:** Overturned

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG-office visit.

**Decision rationale:** Office visit ODG-office visit: Recommended as determined to be medically necessary. Evaluation and management (E & M) outpatient visits to the offices of medical doctors play a critical role in the proper diagnosis and return to function of an injured worker and they should be encouraged. The need for a clinical office visit with a health care provider is individualized based upon a review of the patient concerns, signs and symptoms, clinical stability and reasonable physician judgment. The determination is also based on what medications the patient is taking, since some medications such as opiates or medications such as antibiotics, require close monitoring. As patient conditions are extremely varied, a set number of office visits per condition cannot be reasonably established. The determination of necessity for an office visit requires individualized case review and assessment, being ever mindful that the best patient outcomes are achieved with eventual patient independence from the health care system through self care as soon as clinically feasible. The ODG codes for automated approval (CAA), designed to automate claims management decision-making, indicates the number of E & M office visits (codes 99201-992285) reflecting the typical encounters that are medically necessary for a particular patient. Office visits that exceed the number of office visits listed in the CAA may serve as a “flag” to payors for possible evaluation, however, payors should not automatically deny payment for theirs if preauthorization has not been obtained. Note: the high quality medical studies required for treatment guidelines such as ODG provides guidance about specific treatments and diagnostic procedures but not about the recommended number of E & M office visits. Studies have and are being conducted as to the value of the “virtual visits” compared with inpatient visits, however the value of patient/doctor interventions has not been questions (Dixon 2008) (Wallace 2004). Further ODG does provide guidance for therapeutic office visits not included among the E & M codes for example chiropractic manipulation and Physical/Occupational therapy. (Low Back Chapter). Per review of the clinical data provided, the patient had chronic pain issues and had surgical intervention. Follow up would be indicated.