

Case Number:	CM15-0049080		
Date Assigned:	03/20/2015	Date of Injury:	02/20/2010
Decision Date:	05/06/2015	UR Denial Date:	02/18/2015
Priority:	Standard	Application Received:	03/16/2015

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: Oregon, 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:

The injured worker is a 61-year-old male who reported an injury on 02/02/2010. The mechanism of injury was not specifically stated. The current diagnoses include lumbar disc desiccation, lumbar intervertebral disc herniation, and lumbar radiculitis. The injured worker presented on 01/27/2015, for a follow-up evaluation with complaints of increasing lower back pain, with radiating symptoms into the bilateral lower extremities. The provider noted the injured worker had completed extensive conservative treatment. Upon examination of the lumbar spine, there was a loss of normal lordosis, diminished range of motion and all planes, tenderness over the L4-S1 paravertebral spinal muscles with spasm, and a positive straight leg raise on the left producing back pain and sciatica. Motor strength testing showed weakness of the left extensor hallucis longus, and deep tendon reflexes were hypoactive. Sensory examination revealed diminished sensation to light touch over the left L5 dermatomal distribution. The provider noted the injured worker had failed greater than 6 months of conservative treatment, to include physical therapy, aquatic therapy, home modalities, and acupuncture. Recommendations included a laminectomy, discectomy, and foraminotomy with nerve root decompression at L4-5, with posterior interbody cages and fusion at L4-5. A refill of the current medication regimen was also provided. A Request for Authorization form was then submitted on 02/11/2015.

IMR ISSUES, DECISIONS AND RATIONALES

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

Laminectomy, discectomy and foraminotomy with nerve root decompression at L4-5 with posterior interbody cages and fusion at L4-5 instrumentation, cages and posterolateral fusion at L-5: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Indications for Surgery.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-306. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, Fusion (spinal).

Decision rationale: The California MTUS/ACOEM Practice Guidelines state a referral for surgical consultation is indicated for patients who have severe and disabling lower extremity symptoms; activity limitations for more than 1 month; clear clinical, imaging, and electrophysiologic evidence of a lesion; and a failure of conservative treatment. The Official Disability Guidelines state preoperative surgical indications for a spinal fusion should include the identification and treatment of all pain generators, the completion of all physical medicine and manual therapy interventions, documented instability upon x-ray or CT myelogram, spine pathology that is limited to 2 levels, and a psychosocial screening. In this case, the provider noted an exhaustion of conservative treatment, with a progression of symptoms. There is documentation of radicular symptoms upon examination. However, the provider has also requested updated electrodiagnostic studies. Relevant electrodiagnostic studies are obtained prior to making a surgical decision. The submitted documentation also failed to provide a psychosocial assessment completed prior to the request for a spinal fusion. As such, the request is not medically appropriate.

Norco 10/325mg, #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Hydrocodone/Acetaminophen.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 74-82.

Decision rationale: The California MTUS Guidelines state a therapeutic trial of opioids should not be employed until the patient has failed a trial of nonopioid analgesics. Ongoing review and documentation of pain relief, functional status, appropriate medication use and side effects should occur. The injured worker has utilized the above medication since 06/2014, without any evidence of objective functional improvement. There was also no frequency listed in the request. As such, the request is not medically appropriate.

Alprazolam ER 0.5mg, #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressants for chronic pain.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 24.

Decision rationale: The California MTUS Guidelines state benzodiazepines are not recommended for long term use because long term efficacy is unproven and there is a risk of dependence. In this case, the injured worker does not maintain a diagnosis of anxiety disorder. The medical necessity for the requested medication has not been established. The guidelines do not support long-term use of this medication. There is also no frequency listed in the request. As such, the request is not medically appropriate.

Prilosec 20mg, #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 68-69.

Decision rationale: The California MTUS Guidelines state proton pump inhibitors are recommended for patients at intermediate or high risk for gastrointestinal events. Patients with no risk factor and no cardiovascular disease do not require the use of a proton pump inhibitor, even in addition to a nonselective NSAID. There is no documentation of cardiovascular disease or increased risk factors for gastrointestinal events. As such, the medical necessity for the requested medication has not been established in this case. In addition, there is no frequency listed in the request. As such, the request is not medically appropriate.