MAXIMUS Federal Services

Case Number:	CM15-0088466		
Date Assigned:	05/12/2015	Date of Injury:	09/05/1991
Decision Date:	06/15/2015	UR Denial Date:	04/15/2015
Priority:	Standard	Application Received:	05/08/2015

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:

The injured worker is a 67-year-old male who sustained an industrial injury on 9/05/91. The mechanism of injury was not documented. Past surgical history was positive for anterior and posterior cervical spine fusion. Records indicated that the patient had been prescribed Percocet since at least 7/16/14. The 12/12/14 and 1/14/15, progress reports stated that Percocet was not helpful and Flexeril helped with sleep but not spasms. The 11/17/14 spine surgery report cited low back pain radiating down both legs with difficulty walking. Symptoms were consistent with neurogenic claudication. He had undergone prior physical therapy and epidural injections that made him worse. Physical exam documented normal upper and lower extremity motor function, sensation decreased in the L4, L5, and S1 distributions bilaterally, no Hoffman's, and no clonus. MRI showed grade 1 anterolisthesis of L4 over L5 with severe lumbar stenosis at L4/5 and moderate stenosis at L3/4. There was instability at L4/5. The treatment plan recommended L3/4 and L4/5 decompression and L4/5 instrumented fusion with transforaminal lumbar interbody fusion. The 4/1/15 treating physician report cited 10/10 low back pain radiating to his hips with numbness and tingling down both legs. He reported that pain was worsening and he could not stand up straight or walk. Physical exam documented lumbar paraspinal tenderness from L3/4 to L5/S1, and mild to moderate loss of lumbar range of motion with pain. The diagnosis included lumbar spine degenerative disc and joint disease and grade 1 L4/5 spondylolisthesis. The treatment plan recommended a lumbar brace for prophylactic purposes to avoid exacerbation of current injury. Percocet 10/325 mg 90 tablets was prescribed with report that it helped with moderate pain. Spine surgery was requested per the spine surgeon report. The 4/15/15 utilization

review non-certified the request for spinal fusion surgery as there was no evidence of spinal instability and clinical exam findings did not localize to the proposed levels of surgery. The request for a lumbar spine brace was non-certified as the injured worker was beyond the acute phase of treatment and use in chronic pain was not supported by guidelines. The request for Percocet 10/325 mg was modified to Percocet 10/325 mg #45 acknowledging prior recommendations for weaning and continuing same. The 4/29/15 treating physician report stated that certification had been provided for lumbar decompression surgery at L3-L5. The treating physician opined that this certification for decompression was reasonable as there was no instability in the low back at the present time. The 5/4/15 spine surgeon report cited continued low back pain radiating down the bilateral legs with symptoms of neurogenic claudication. Physical exam documented no obvious spinal deformity, normal motor function in all extremities, and decreased sensation in the L4, L5, and S1 distributions bilaterally. The spine surgeon stated that the injured worker had clear instability at L4/5 which was evidenced by anterolisthesis at this level. A fusion was required at the L4/5 level.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 Spine fusion surgery: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 307, 310. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back - Lumbar & Thoracic, Hardware implant removal (fixation), Patient selection criteria for Lumbar Spinal Fusion.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 307. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Lumbar & Thoracic, Fusion (spinal).

Decision rationale: The California MTUS guidelines indicate that lumbar spinal fusion may be considered for patients with increased spinal instability after surgical decompression at the level of degenerative spondylolisthesis. Guidelines state there was no good evidence that spinal fusion alone was effective for treating any type of acute low back problem, in the absence of spinal fracture, dislocation, or spondylolisthesis if there was instability and motion in the segment operated on. The Official Disability Guidelines (ODG) state that spinal fusion is recommended as an option for spinal fracture, dislocation, spondylolisthesis or frank neurogenic compromise, subject to the selection criteria. Fusion is recommended for objectively demonstrable segmental instability, such as excessive motion with degenerative spondylolisthesis. Spinal instability criteria includes lumbar inter-segmental 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, spine pathology limited to 2 levels, and psychosocial screening with confounding issues addressed. For any potential fusion surgery, it is recommended that the patient refrain from smoking for at least 6 weeks prior to surgery and during the period of fusion healing. Guideline criteria have not been met. This patient presents with low back pain radiating to the bilateral lower extremities with decreased sensation in the L4, L5, and S1 distributions bilaterally. Records indicate that the decompression surgery has

been certified at the L3/4 and L4/5 levels for spinal stenosis. There is reported imaging evidence of anterolisthesis at the L4/5 level. There is no radiographic evidence of spinal segmental instability consistent with guidelines in the available records to support the medical necessity of fusion. Additionally, there is no evidence of a psychosocial screen or documentation of smoking status to fulfill the guideline criteria for fusion. Therefore, this request is not medically necessary at this time.

1 Lumbar spine brace: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 298, 30.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 301. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM). Occupational Medical Practice Guidelines 2nd Edition. Chapter 12 Low Back Disorders. (Revised 2007) page(s) 138-139.

Decision rationale: The California MTUS guidelines state that lumbar supports have not been shown to have any lasting benefit beyond the acute phase of symptom relief. The revised ACOEM Low Back Disorder guidelines do not recommend the use of lumbar supports for prevention or treatment of lower back pain. However, guidelines state that lumbar supports may be useful for specific treatment of spondylolisthesis, documented instability, or post-operative treatment. Guideline criteria have been met. This injured worker has been reportedly certified for lumbar decompression surgery and has been diagnosed with spondylolisthesis. The use of lumbar support is consistent with guidelines. Therefore, this request is medically necessary.

Percocet 10/325mg: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use, Percocet.

Decision rationale: The California MTUS guidelines support the use of Percocet for moderate to moderately severe pain on an as needed basis. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. On-going management requires review and documentation of pain relief, functional status, appropriate medication use, and side effects. Guidelines suggest that opioids be discontinued if there is no overall improvement in function, unless there are extenuating circumstances. Gradual weaning is recommended for long-term opioid users because opioids cannot be abruptly discontinued without probable risk of withdrawal symptoms. Guideline criteria have not been met. The use of Percocet is documented in the records since at least 7/16/14. The progress reports have noted a reduction in pain with rest and activity modified. There was mixed documentation relative to response to Percocet with the 12/12/14 and 1/14/15 stating that Percocet was not helpful. Records suggest that weaning of Percocet has been previously recommended. The 4/15/15 utilization review modified the request for Percocet 10/325 mg to Percocet 10/325 mg #45 to allow for continued weaning. There is no documentation of objective functional improvement with the use of Percocet to support on-going use beyond the amount previously certified. Therefore, this request is not medically necessary.