

Case Number:	CM14-0028049		
Date Assigned:	06/16/2014	Date of Injury:	12/01/2010
Decision Date:	09/15/2014	UR Denial Date:	02/10/2014
Priority:	Standard	Application Received:	03/05/2014

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. The expert reviewer is Board Certified in Orthopedic Surgery and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 67-year-old female sustained an industrial injury on 12/1/10, due to repetitive work duties. The patient was status post left carpal tunnel release and deQuervain's release in March 2011, left wrist surgery in 2012, and anterior cervical discectomy and fusion C4 to C6 on 3/1/13. The 10/16/13 lumbar MRI impression documented an L2/3 disc protrusion/extrusion with no nerve root compromise, an L3/4 disc protrusion/extrusion with left foraminal compromise, an L4/5 disc protrusion/extrusion with compromise of the bilateral exiting nerve roots, and an L5/S1 disc protrusion/extrusion with foraminal encroachment and nerve root compromise. The 11/05/13 bilateral lower extremity EMG/NCV was normal, with no indicators of acute lumbar radiculopathy. The 12/18/13 treating physician report cited continued lumbar symptoms extending into the lower extremities. She had failed activity modification, physical therapy, and pain management. She did not wish to consider further injection blocks. She had significant difficulties with activities of daily living and ambulation. She reported giving way of her legs and dragging her feet. The lumbar spine exam documented tenderness, guarded and restricted lumbar flexion/extension, no significant radiculopathy in the lower extremities, some dysesthesias, and some generalized lower extremity weakness. Motor strength was 3+ to 4-/5 in the L5 and S1 innervated motor groups. Given the multilevel lumbar spondylosis and some instability, the treating physician opined the only option was surgical intervention with the progressive neurologic deficit that was present. The request was for L3 to S1, possible L2-3, posterior lumbar interbody fusion (PLIF) with possible reduction of listhesis. The 2/10/14 utilization review denied the request for lumbar fusion surgery as there was no documentation that the patient would require facetectomies to accomplish decompression and no imaging evidence of segmental instability. Additionally, there was no documentation of psychological clearance for surgery. The associated post-surgical requests were also denied. Cyclobenzaprine

and Omeprazole were denied based on absence of guideline support for continued use. Tramadol was modified to #30 to allow for weaning as the documentation provided did not contain evidence of functional improvement with use.

IMR ISSUES, DECISIONS AND RATIONALES

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

TRAMADOL HYDROCHLORIDE ER 150 MG #90: 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, Tramadol Page(s): 76-80, 93-94, 113.

Decision rationale: The California MTUS indicate that opioids, such as Tramadol, are recommended 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. In general, continued and long-term use of opioids is contingent upon a satisfactory response to treatment that may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. Guideline criteria have not been met for continued use of this medication. There is no current pain assessment indicating the level of pain or what benefit has been achieved with the use of this medication. There is no current functional assessment or documentation of objective functional benefit with use of this medication. As functional benefit to this medication was not documented, the 2/10/14 utilization review recommended modification and approval of Tramadol hydrochloride ER 150 mg #30 to allow for weaning. There is no compelling reason to support the medical necessity of continued Tramadol, beyond the modification, in the absence of documented functional improvement. Therefore, this request for Tramadol hydrochloride ER 150 mg #90 is not medically necessary and appropriate.

L3 TO S1 POSSIBLE L2-3, POSTERIOR LUMBAR INTERBODY FUSION (PLIF) WITH POSSIBLE REDUCTION OF LISTHESIS: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation ACOEM-SURGICAL CONSIDERATIONS, CHAPTER 12.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back - Lumbar & Thoracic, Fusion (Spinal).

Decision rationale: The ACOEM revised low back guidelines state that lumbar fusion is not recommended as a treatment for patients with radiculopathy from disc herniation. Lumbar fusion is not recommended as a treatment for spinal stenosis unless concomitant instability or deformity has been proven. The Official Disability Guidelines (ODG) state that spinal fusion is not recommended for patients who have less than six months of failed recommended conservative

care unless there is objectively demonstrated severe structural instability and/or acute or progressive neurologic dysfunction. Fusion is recommended for objectively demonstrable segmental instability, such as excessive motion with degenerative spondylolisthesis. 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. Guideline criteria have not been met. Imaging findings documented nerve root compromise from L3 through S1 but clinical exam findings are consistent with the L5/S1 findings. There is no radiographic evidence of spinal segmental instability. There is no detailed documentation that recent comprehensive pharmacologic and non-pharmacologic conservative treatment had been tried and failed. Physical therapy was provided for the cervical spine post-op, but there is no documentation of physical therapy to the low back. The patient was scheduled for a lumbar epidural injection on 11/26/13, but there is no documentation of this occurring and what benefit may have been achieved. There is no evidence of a psychosocial screen. Therefore, this request for L3 to S1 possible L2-3, posterior lumbar interbody fusion (PLIF) with possible reduction of listhesis is not medically necessary and appropriate.

SURGERY ASST: 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: Since the primary procedure is not med necessary, none of the associated services are medically necessary.

INPATIENT STAY THREE DAYS: 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: Since the primary procedure is not med necessary, none of the associated services are medically necessary.

MEDICAL CLEARANCE WITH INTERNIST: 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: Since the primary procedure is not med necessary, none of the associated services are medically necessary.

FRONT WHEEL WALKER: 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: Since the primary procedure is not med necessary, none of the associated services are medically necessary.

ICE UNIT: 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: Since the primary procedure is not med necessary, none of the associated services are medically necessary.

BONE SITMULATOR: 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: Since the primary procedure is not med necessary, none of the associated services are medically necessary.

TLSO: 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: Since the primary procedure is not med necessary, none of the associated services are medically necessary.

3-1 COMMODE: 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: Since the primary procedure is not med necessary, none of the associated services are medically necessary.

CYCLOBENZAPRINE HYDROCHLORIDE TABLETS 7.5 MG #120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants (for pain).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain) Page(s): 63-65.

Decision rationale: The California MTUS guidelines recommend non-sedating muscle relaxants with caution as a second-line option for short term treatment of acute exacerbations in patients with chronic lower back pain. Cyclobenzaprine is not recommended to be used for longer than 2 to 3 weeks. Guideline criteria have not been met for use of this medication. It is unclear if this is a post-operative request or a current treatment request. The associated surgery is not medically necessary. There is no evidence that she is currently taking Cyclobenzaprine. There is no documentation that she is in an acute exacerbation of her chronic low back pain or suffers muscle spasms. There is no clear indication for the use of this medication. Therefore, this request for Cyclobenzaprine hydrochloride tablets 7.5 mg #120 is not medically necessary and appropriate.

ONDANSETRON ODT TABLETS 8 MG #30 X 2: 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: Since the primary procedure is not med necessary, none of the associated services are medically necessary.

OMEPRAZOLE DELAYED RELEASE CAPSULES 20 MG #120: Overturned

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 NSAIDS, GI symptoms & cardiovascular risk Page(s): 68-69.

Decision rationale: The California MTUS guidelines recommend the use of proton pump inhibitors (PPIs), such as Prilosec, for patients at risk for gastrointestinal events. Risk factors include age greater than 65 years, history of peptic ulcer, gastrointestinal bleeding or perforation, concurrent use of ASA, corticosteroids, and/or an anticoagulant, or high dose/multiple NSAID

(e.g., NSAID + low-dose ASA). PPIs are reported highly effective for their approved indications, including preventing gastric ulcers induced by NSAIDs. Guideline criteria for intermediate gastrointestinal risk factors have been met. The patient is over 65 years with concomitant use of Naprosyn. Therefore, this request for Prilosec 20 mg #60 is medically necessary.