MAXIMUS Federal Services

Case Number:	CM14-0214456		
Date Assigned:	02/04/2015	Date of Injury:	06/19/2009
Decision Date:	03/30/2015	UR Denial Date:	11/26/2014
Priority:	Standard	Application Received:	12/22/2014

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. 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: Minnesota, Florida
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 65-year-old male sustained a work-related back injury on 6/19/2009. According to the progress notes dated 12/3/2014, the injured worker's (IW) diagnoses are multilevel discogenic disease with stenosis, chronic lumbar spine sprain/strain, chronic low back pain, lumbar facet arthropathy and annular tear L3-4, L4-5 and L5-S1. He reports his back pain has increased and he has difficulty walking; medications increase his functionality. Previous treatment includes medications, epidural steroid injections and physical therapy. The treating provider requests one L3-S1 fusion, a co-surgeon, a three day inpatient stay, a post-operative brace, 3-in-1 commode, front-wheeled walker, post-op home health evaluation, consultation with a vascular surgeon, a home health aide for four hours daily, five days per week for two weeks and single prescriptions for the following medications: Ativan 1mg, #30, Neurontin 600mg, #30, Norco 10/325mg, #180 and an unknown prescription for Melatonin. The Utilization Review on 11/26/2014 modified the request for Norco to one prescription of Norco 10/325mg #120; the remaining services, L3-S1 fusion, a co-surgeon, a three day inpatient stay, a post-operative brace, 3-in-1 commode, front-wheeled walker, post-op home health evaluation, consultation with a vascular surgeon, a home health aide for four hours daily, five days per week for two weeks and single prescriptions for the following medications: Ativan 1mg, #30, Neurontin 600mg, #30, and an unknown prescription for Melatonin were non-certified, citing Official Disability Guidelines (ODG), California MTUS Chronic Pain Medical Treatment guidelines and ACOEM guidelines, Chapter 12.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 L3-S1 Fusion: Upheld

Claims Administrator 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 (Acute and Chronic)

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 307, 310.

Decision rationale: California MTUS guidelines indicate that patients with increased spinal instability after surgical decompression at the level of degenerative spondylolisthesis may be candidates for a fusion. Documentation does not any spondylolisthesis or instability. The guidelines also state that there is no scientific evidence about the long-term effectiveness of any form of surgical decompression or fusion for degenerative lumbar spondylosis compared with natural history, placebo, or conservative treatment. There is no good evidence from controlled trials that spinal fusion alone is effective for treating any type of acute low back problem in the absence of spinal fracture, dislocation, or spondylolisthesis if there is instability and motion in the segment operated on. Based upon the California MTUS guidelines in the absence of instability and in the absence of fracture, dislocation, complications of tumor, or infection, a spinal fusion is not supported by guidelines and as such, the medical necessity of the request for L3-S1 fusion is not substantiated.

Associated surgical service: 3 day inpatient stay: 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 medically necessary, none of the associated services are medically necessary.

Associated surgical service: 1 co- surgeon: 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 medically necessary, none of the associated services are medically necessary.

1 post operative brace: 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 medically necessary, none of the associated services are medically necessary.

1 post operative home health evaluation: 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 medically necessary, none of the associated services are medically necessary.

Associated surgical service: 1 home health aide 4 hours per day, 5 days per week, for 2 weeks: 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 medically necessary, none of the associated services are medically necessary.

Associated surgical service: 3 in 1 commode Qty: 1.00: 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 medically necessary, none of the associated services are medically necessary.

Associated surgical service: 1 front wheeled 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 medically necessary, none of the associated services are medically necessary.

1 consult with a vascular surgeon: 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 medically necessary, none of the associated services are medically necessary.

1 prescription of Ativan 1mg #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

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

Decision rationale: The chronic pain guidelines do not recommend long term use of Benzodiazepines. Tolerance to hypnotic effects develops rapidly and anxiolytic effects within months and use may actually increase anxiety. A more appropriate treatment is an anti-depressant. As such, the request for Ativan 1 mg # 30 is not supported and the medical necessity is not established.

1 prescription of Neurontin 600mg #30: Overturned

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Gabapentin (Neurontin) Page(s): 18.

Decision rationale: Gabapentin has been shown to be effective for treatment of diabetic peripheral neuropathy and post herpetic neuralgia and is considered a first line treatment for neuropathic pain. It has an anti-anxiety effect. It is recommended for lumbar spinal stenosis as a trial with statistically significant improvement followed in walking distance, pain with movement, and sensory deficit found in a pilot study. The documentation indicates the presence of neural foraminal stenosis at multiple levels and as such, the request for Neurontin is appropriate and the medical necessity of the request is substantiated.

1 prescription of Norco 10/325mg #180: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 80, 81, 82.

Decision rationale: Opioids are not recommended as a first line therapy for neuropathic pain. Opioids appeared to be efficacious but limited for short-term pain relief and long term efficacy is unclear in chronic back pain. In patients taking opioids for back pain the prevalence of lifetime substance use disorders has ranged from 36% to 56%. Up to one fourth of patients who receive opioids exhibit aberrant medication taking behavior. It is suggested that rather than simply focus on pain severity, improvements in a wide range of outcomes should be evaluated including measures of functioning, appropriate medication use, and side effects. A recent epidemiologic study found that opioid treatment for chronic nonmalignant pain did not seem to fulfill any of the outcome goals including pain relief, improved quality of life, and or improved functional capacity. Weaning is suggested and the modification by utilization review is appropriate. As such, the request for the prescription for Norco 10/325 mg # 180 is not supported and the medical necessity of this request is not substantiated.

Unknown prescription of Melatonin: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Mental Illness & Stress

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines: Melatonin

Decision rationale: ODG guidelines recommend melatonin for delayed sleep phase syndrome. It appears to reduce sleep onset latency to a greater extent in people with delayed sleep phase syndrome than in people with insomnia. It is also said to have an analgesic role and it is hypothesized that improved sleep may reduce anxiety and subsequently improve pain. It has been studied in fibromyalgia with significant improvement. As such, the use of melatonin is supported by guidelines. The request as stated does not indicate the dosage or quantity of melatonin and therefore medical necessity cannot be determined.