

Case Number:	CM15-0164932		
Date Assigned:	09/02/2015	Date of Injury:	11/16/2003
Decision Date:	11/19/2015	UR Denial Date:	07/21/2015
Priority:	Standard	Application Received:	08/21/2015

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: New York, Montana, 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 74 year old female, who sustained an industrial injury on November 16, 2003. She reported low back pain, left shoulder and forearm pain with tingling and numbness, neck pain, left knee pain and left lower extremity weakness. The injured worker was diagnosed as having lumbar strain with right radicular symptoms and signs with spontaneous exacerbations, cervical strain and radiculopathy, left greater than right with spontaneous exacerbations, status post cervical fusion on December 7, 2009, left knee pain, status post-surgical intervention on February, 2004 and September, 2006, posterior tibial nerve injury, status post right knee surgery in February, 2006, post-traumatic headaches, secondary depression related to pain, coccygeal sprain, insomnia secondary to pain, intermittent upset stomach secondary to medication use and left shoulder pain with radiculopathy. Treatment to date has included diagnostic studies, radiographic imaging, and durable medical equipment for mobility, lumbar fusion on September 23, 2014, extensive conservative care, medications and activity restrictions. Currently, the injured worker continues to report low back pain with radiation to bilateral lower extremities, neck pain with radiation to the shoulders, left shoulder pain with radiation to the left arm into her forearm and her fingers with associated numbness and tingling, mild left lower extremity weakness and numbness, post-operative left total knee replacement surgery from nerve damage, left knee pain improved slightly after surgery, increased with prolonged walking, headaches improved since cervical spine surgery on December 7, 2009, depression secondary to chronic pain, tailbone and coccyx pain, sleep difficulties and upset stomach secondary to medication use. The injured worker reported an industrial injury in 2003, resulting in the above noted pain. She

was treated conservatively and surgically without complete resolution of the pain. Evaluation on May 18, 2015, revealed continued pain as noted. There was decreased range of motion (ROM) noted in the cervical and lumbar spine, knees and left shoulder. Cervical spine Spurling's test was noted as positive. It was noted the gait was slow and she used a 4-point cane for ambulation. Evaluation on July 10, 2015, revealed continued pain as noted. She rated her lumbar pain at 4 on a 1-4 scale with 4 being the worst. External bone growth stimulator, 1 box island bandage, inpatient Stay for 3 Days, lumbar brace, physical therapy 3xwk x 6wks, lumbar spine, surgical assistant, Diazepam 5mg #100 Refill 2, L3-L4 Transforaminal Lumbar Interbody Fusion and Posterior Spinal Instrumentation, L4-S1 Remove and Explore, L3-S1 Posterior Spinal Fusion and Percocet 10-325mg #100 were requested.

IMR ISSUES, DECISIONS AND RATIONALES

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

L3-L4 Transforaminal Lumbar Interbody Fusion and Posterior Spinal Instrumentation, L4-S1 Remove and Explore, L3-S1 Posterior Spinal Fusion: Upheld

Claims Administrator guideline: Decision based on MTUS Low Back Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines, Online Version, Hardware implant removal (fixation).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Medications for chronic pain.

Decision rationale: The California MTUS guidelines recommend lumbar surgery if there is severe persistent, debilitating lower extremity complaints, clear clinical and imaging evidence of a specific lesion corresponding to a nerve root or spinal cord level, corroborated by electrophysiological studies which is known to respond to surgical repair both in the near and long term. Documentation does not provide this evidence. The California MTUS Guidelines do recommend lumbar fusion if the patient has had a fracture, dislocation or evidence of significant instability. Documentation does not provide this evidence. The requested treatment: L3-L4 Transforaminal Lumbar Interbody Fusion and Posterior Spinal Instrumentation, L4-S1 Remove and Explore, L3-S1 Posterior Spinal Fusion is not medically necessary and appropriate.

Associated surgical service: Surgical Assistant: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back, Online Version, Surgical assistant.

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: In-Patient Stay for 3 Days: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back, Hospital length of stay (LOS).

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: Physical therapy 3xwk x 6wks, lumbar spine: Upheld

Claims Administrator guideline: Decision based on MTUS Postsurgical Treatment 2009.

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: Lumbar brace: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Low Back-online version- Back brace, post operative (fusion).

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: External bone growth stimulator: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Low Back-online version, Bone growth stimulators (BGS).

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 box island bandage: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Low Back-online version, Wound dressings.

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.

Diazepam 5mg #100 Refill 2: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Muscle relaxants (for pain).

Decision rationale: The California MTUS Guidelines do not recommend benzodiazepines because of the rapid development of tolerance and dependency. Documentation does not provide rationale for chronic use. The requested service is not medically necessary or appropriate.

Percocet 10-325mg #100: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids (Classification).

Decision rationale: The requested treatment: Percocet (Oxycodone) 10-325mg #100 is not medically necessary and appropriate because the California MTUS guidelines note that a treatment program for chronic pain should be established which will assure functional improvement and diminished chances for abuse and dependence. The amount of 100 tablets in this prescription does not do this. The Guidelines indicate the treatment plan should address the four A's. Documentation does not show this compliance. The California MTUS guidelines p.92 note that Oxycodone should initially be administered 2.5 to 5 mg every four to 6 hours. The guidelines p78- further recommend that the lowest possible dose to gain effect should be chosen. In the management of the patient receiving opioids, the guidelines also recommend the patient keep a diary and the provider monitor the patient for physical and psychosocial functionality and side effects. Documentation does not provide this evidence. The requested treatment: Oxycodone 10-325mg#100 is not medically necessary and appropriate.