MAXIMUS Federal Services

Case Number:	CM15-0171703		
Date Assigned:	10/15/2015	Date of Injury:	02/25/2013
Decision Date:	12/08/2015	UR Denial Date:	08/05/2015
Priority:	Standard	Application Received:	08/31/2015

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: California
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 35-year-old male with an industrial injury dated 02-25-2013. A review of the medical records indicates that the injured worker is undergoing treatment for L4-5 and L5-S1 disc degeneration, L4-S1 disc displacement, L5-S1 stenosis, right leg radiculopathy and chronic intractable pain. According to the progress note dated 07-13-2015, the injured worker reported ongoing low back pain with numbness radiating into the right buttocks and down the posterior thigh through the calf into the plantar aspect of the foot. Current Medications: Norco (since at least 05-27-2015) and Anaprox Ds (since at least 05-27-2015). Pain level (05-27-2015, 06-24-2015, and 07-13-2015) was 7 out of 10 with medication and 10 out of 10 without medication on a visual analog scale (VAS). Objective findings (06-24-2015, 07-13-2015) revealed tenderness to palpitation over the L4-5 and L5-S1 lumbar paraspinal musculature and positive straight leg raises on the right. The treating physician reported that the Magnetic Resonance Imaging (MRI) of the lumbar spine dated 07-02-2013 revealed "moderate disc height loss L4-5 and L5-S1. L5-S1 revealed right paracentral disc herniation causing mild to moderate lateral recess stenosis." The treating physician reported Magnetic Resonance Imaging (MRI) scan of the lumbar spine dated 06-29-2015 revealed "a moderate disc height loss at L4-5 and L5-S1, extruded disc herniation at L4-5 with a large annular tear, broad based disc bulge at L5-S1 with a large annular tear, and moderate bilateral foraminal stenosis of L5-S1 and mild at L4-5." X ray of lumbar spine dated 07-02-2013 revealed mild disc height loss at L4-5 and moderate disc height loss at L5-S1. Treatment has included Magnetic Resonance Imaging (MRI)'s and X-rays of lumbar spine, prescribed medications, physical therapy, epidural steroid injection (ESI) and periodic follow up

visits. Treatment plan consisted of request for lumbar surgery, associated surgical services and medication management. The utilization review dated 08-05-2015, non-certified the request for Anaprox 550mg #60 with 3 refills, L4-L5 and L5-S1 discectomy and fusion, pre-operative medical clearance, post-op physiotherapy visits x18, associated surgical services: chest x-ray, lumbar-sacral orthosis (LSO) back brace, front wheel walker, pneumatic Intermittent compression device (30 day rental), bone growth stimulator purchase, and modified the request for Norco 10-325mg #80 (original: #160).

IMR ISSUES, DECISIONS AND RATIONALES

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

L4-L5 and L5-S1 discectomy and fusion: Upheld

Claims Administrator guideline: Decision based on MTUS Low Back Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines Treatment in Workers' Compensation (ODG-TWC) online edition 2015, Low Back- Lumbar & Thoracic: Fusion (Spinal).

MAXIMUS guideline: Decision based on MTUS Low Back Complaints 2004, Section(s): Surgical Considerations. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, Fusion.

Decision rationale: The ACOEM Guidelines Chapter 12 Low Back Complaints page 307 states that lumbar fusion, except for cases of trauma-related spinal fracture or dislocation, is not usually considered during the first three months of symptoms. Patients with increased spinal instability (not work-related) after surgical decompression at the level of degenerative spondylolisthesis may be candidates for fusion. According to the ODG, Low back, Fusion (spinal) should be considered for 6 months of symptom. Indications for fusion include neural arch defect, segmental instability with movement of more than 4.5 mm, revision surgery where functional gains are anticipated, infection, tumor, deformity and after a third disc herniation. In addition, ODG states, there is a lack of support for fusion for mechanical low back pain for subjects with failure to participate effectively in active rehab pre-op, total disability over 6 months, active psych diagnosis, and narcotic dependence. In this particular patient, there is lack of medical necessity for lumbar fusion, as there is no evidence of segmental instability greater than 4.5 mm, severe stenosis or psychiatric clearance from the exam note of 7/13/15 to warrant fusion. Therefore, the request is not medically necessary.

Pre-operative medical clearance: 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.

Post-op physiotherapy visits x18: 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: chest x-ray: 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: lumbar-sacral orthosis (LSO) back 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.

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

Associated surgical service: Pneumatic Intermittent Compression Device (30-day rental): 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: Bone Growth Stimulator purchase: 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.

Norco 10/325mg #160: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids, criteria for use, Opioids, dosing, Opioids, specific drug list.

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

Decision rationale: According to the CA MTUS/Chronic Pain Medical Treatment Guidelines, page 80, opioids should be continued if the patient has returned to work and the patient has improved functioning and pain. Based upon the records reviewed there is insufficient evidence to support chronic use of narcotics. There is lack of demonstrated functional improvement, percentage of relief, demonstration of urine toxicology compliance or increase in activity from the exam note of 7/13/15. Therefore, the request is not medically necessary.

Anaprox 550mg #60 with 3 refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): NSAIDs, specific drug list & adverse effects.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): NSAIDs (non-steriodal anti-inflammatory drugs).

Decision rationale: Per the CA MTUS/Chronic Pain Medical Treatment Guidelines, page 66 states that Naproxen is a non-steroidal anti-inflammatory drug (NSAID) for the relief of the signs and symptoms of osteoarthritis. It is used as first line treatment but long-term use is not warranted. In this case, the continued use of Naproxen is not warranted, as there is no demonstration of functional improvement from the exam note from 7/13/15. Therefore, the request is not medically necessary.