

Case Number:	CM15-0174937		
Date Assigned:	09/25/2015	Date of Injury:	05/04/2012
Decision Date:	11/09/2015	UR Denial Date:	08/21/2015
Priority:	Standard	Application Received:	09/04/2015

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
 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 66 year old male who sustained an industrial injury on 05-04-2012. Current diagnoses include adjacent segment disease, lumbar stenosis, lumbar herniated nucleus pulposus, cauda equina, and lumbar radiculopathy. Report dated 08-12-2015 noted that the injured worker presented with complaints that included worsening back and leg pain. The injured worker presented to review MRI and EMG study. Pain level was not included. Physical examination performed on 08-12-2015 revealed an uncomfortable looking appearance, walks with a very forward flexed posture, mildly tender to palpation over the sacroiliac joints, negative straight leg raises, and normal motor testing in the lower extremities. Previous diagnostic studies include lumbar spine X-rays, EMG-NCS dated 07-30-2015, and lumbar spine MRI dated 08-07-2015 which shows severe stenosis at levels L2-L4 with disc protrusions at both levels. Previous treatments included medications, lumbar surgery on 02-17-2015, and physical therapy. The treatment plan included recommendation for surgical intervention. Request for authorization dated 08-14-2015, included requests for posterior transforaminal interbody fusion at L2-3, posterior transforaminal interbody fusion at L3-4, removal of posterior segmental instrumentation, exploration of spinal fusion, posterior fusion single level, posterior fusion additional level, posterior segmental instrumentation, assistant surgeon, inpatient stay for 3 days, post-operative physical therapy x 18, lumbar brace, Percocet 10/325mg #100, Diazepam 5mg #100, external bone growth stimulator, and island bandage (1 box). The utilization review dated 08-21-2015, non-certified/modified the request for posterior transforaminal interbody fusion at L2-3, posterior transforaminal interbody fusion at L3-4, removal of posterior segmental

instrumentation, exploration of spinal fusion, posterior fusion single level, posterior fusion additional level, posterior segmental instrumentation, assistant surgeon, inpatient stay for 3 days, post-operative physical therapy x 18, lumbar brace, Percocet 10/325mg #100, Diazepam 5mg #100, external bone growth stimulator, and island bandage (1 box).

IMR ISSUES, DECISIONS AND RATIONALES

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

Posterior Transforaminal Interbody Fusion at L2-3: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Low Back Complaints 2004, Section(s): Surgical Considerations.

Decision rationale: California MTUS guidelines do recommend spinal fusion for fracture, dislocation and instability. Documentation does not provide evidence of this. The requested treatment: Posterior Transforaminal Interbody Fusion at L2-3 is not medically necessary and appropriate.

Posterior Transforaminal Interbody Fusion at L3-4: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Low Back Complaints 2004, Section(s): Surgical Considerations.

Decision rationale: California MTUS guidelines do recommend spinal fusion for fracture, dislocation and instability. Documentation does not provide evidence of this. The requested treatment: Posterior Transforaminal Interbody Fusion at L3-4 is not medically necessary and appropriate.

Removal of Posterior Segmental Instrumentation: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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 Chapter-Hardware removal.

Decision rationale: The ODG guidelines do recommend removal of hardware if it broken or found to be a pain generator. Documentation does not provide evidence either is the case. The requested treatment: Removal of Posterior Segmental Instrumentation is are not medically necessary and appropriate.

Exploration of Spinal Fusion: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Low Back Complaints 2004, Section(s): Surgical Considerations.

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. Rationale for exploration of the patient's lumbar fusion is not provided. The requested Treatment: Exploration of Spinal Fusion is not medically necessary and appropriate.

Posterior Fusion Single Level: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Low Back Complaints 2004, Section(s): Surgical Considerations.

Decision rationale: California MTUS guidelines do recommend spinal fusion for fracture, dislocation and instability. Documentation does not provide evidence of this. The requested treatment: Posterior Fusion Single Level is not medically necessary and appropriate.

Posterior Fusion Additional Level: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Low Back Complaints 2004, Section(s): Surgical Considerations.

Decision rationale: California MTUS guidelines do recommend spinal fusion for fracture, dislocation and instability. Documentation does not provide evidence of this. The requested treatment: Posterior Fusion Additional Single Level is not medically necessary and appropriate.

Associated Surgical Service: Inpatient stay for 3 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: As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.

Assistant 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: As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.

Posterior Segmental Instrumentation: 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: As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.

Post-operative Physical Therapy QTY: 18: 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: As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.

Associated Surgical Service: Lumbar 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: As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.

Percocet 10/325mg #100: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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

Decision rationale: The MTUS guidelines note that opioids are rarely beneficial in cases where the pain is due to mechanical or compressive etiologies. They note that opioids are not recommended as a first-line therapy for neuropathic pain. Since the documentation shows the patient was still taking Percocet four months after his lumbar fusion, as noted by the guidelines, tolerance and abuse have to be assayed. The documentation does not show this plan. Measures of pain assessment are advised as well as improved functional capacity. The guidelines note that chronic lumbar radicular pain did not respond to tricyclic antidepressants or opioids in doses effective for postherpetic neuralgia. The patient's neurological and physical examination in the post-operative period noted improvement, and the frequency had been reduced to twice a day before increasing the dose without documentation of why or what the course would be. The requested treatment: Percocet 10/325mg #100 is not medically necessary and appropriate.

Diazepam 5mg #100: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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

Decision rationale: The California MTUS Guidelines indicate for treatment of muscle spasm that the use of benzodiazapines is not recommended because of the likelihood of dependency and tolerance. The requested treatment: Diazepam 5mg #100 is not medically necessary and appropriate.

Associated Surgical Service: External Bone Growth Stimulator: 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: As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.

Island Bandage (1 box): 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: As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.