

<b>Case Number:</b>	CM15-0036976		
<b>Date Assigned:</b>	03/05/2015	<b>Date of Injury:</b>	05/04/2010
<b>Decision Date:</b>	06/10/2015	<b>UR Denial Date:</b>	02/02/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/27/2015

### 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

Certification(s)/Specialty: Pediatrics, Internal Medicine

### 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 61 year old male, who sustained an industrial injury on 5/4/10. The injured worker has complaints of back pain that radiates to the left leg and numbness of left foot. The diagnoses have included opioids type dependence; gout; methicillin-resistant staphylococcus aureus infections; leg pain and back pain. Treatment to date has included epidural injections; cortisone injections; physical therapy and pain management. The injured worker is to have left L4-5 interlaminar laminotomy, microdiscectomy and decompression. According to the utilization review performed on 2/20/15, the requested Pre-op internal medicine clearance has been modified to Pre-op internal medicine clearance to include CBC, BMP and electrocardiogram (EKG). The requested Post-op rehabilitation physical therapy 1x24 (lumbar) has been modified to Post-op rehabilitation physical therapy 1x12 (lumbar). The requested front wheeled walker has been non-certified. The requested transportation has been non-certified. The requested prospective use of Norco 10/325mg #135 has been non-certified and the requested prospective use of Zanaflex 2mg #90 has been modified to Zanaflex 2mg #20. The requested left L4-5 interlaminar laminotomy, microdiscectomy and decompression; Assistant surgeon/PA; 1 day hospital stay; Off the shelf lumbar brace; Post-op home health RN/evaluation x 1 visit and Prospective use of Tramadol 50mg #30 has been certified. California Medical Treatment Utilization Schedule (MTUS), American College of Occupational and Environmental Medicine (ACOEM) and Official Disability Guidelines was used in the utilization review.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Pre-op internal medicine clearance to include CBC, BMP and EKG: 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) - TWC.

**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 - Preoperative testing, general.

**Decision rationale:** Preoperative testing (e.g., chest radiography, electrocardiography, laboratory testing, urinalysis) is often performed before surgical procedures. These investigations can be helpful to stratify risk, direct anesthetic choices, and guide postoperative management, but often are obtained because of protocol rather than medical necessity. The decision to order preoperative tests should be guided by the patient's clinical history, comorbidities, and physical examination findings. An alternative to routine preoperative testing for the purpose of determining fitness for anesthesia and identifying patients at high risk of postoperative complications may be to conduct a history and physical examination, with selective testing based on the clinician's findings. A preoperative evaluation would be medically necessary. However, screening CBC, BMP and EKG are not medically necessary as the IW had no medical history or symptoms that would indicate need for such testing. This request is not medically necessary.

**Post-op rehabilitation physical therapy 1x12 (lumbar): Overturned**

**Claims Administrator guideline:** Decision based on MTUS Postsurgical Treatment Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Postsurgical Treatment Guidelines  
Page(s): 25.

**Decision rationale:** Per MTUS and ODG guidelines, postsurgical physical therapy for intervertebral disc disorder with myelopathy is recommended. The maximum treatment recommendations are 48 visits over 18 weeks. This request is medically necessary.

**Front wheeled walker: 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)-TWC Knee and Leg Procedure summary.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee & Leg Chapter - Walking aids (canes, crutches, braces, orthoses, & walkers).

**Decision rationale:** Per ODG guidelines, walking aids are recommended, as indicated below. Frames or wheeled walkers are preferable for patients with bilateral disease. The documentation

provided notes that the IW had Left LE radiculopathy and not bilateral disease. The request is not medically necessary.

**Transportation:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines -Knee and Leg Procedure Summary Department of Health Care Services-California [www.dhcs.ca.gov/services/medi-cal](http://www.dhcs.ca.gov/services/medi-cal) Criteria for Medical Transportation.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee & Leg - Transportation (to & from appointments).

**Decision rationale:** Per ODG guidelines transportation is recommended for medically-necessary transportation to appointments in the same community for patients with disabilities preventing them from self-transport. Note: This reference applies to patients with disabilities preventing them from self-transport who are age 55 or older and need a nursing home level of care. There is no notation that the IW requires nursing home level of care and thus the request is not medically necessary.

**Prospective use of Norco 10/325mg #135:** Overturned

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

**Decision rationale:** Per ACOEM low back chapter comfort measures are indicated for short term use following surgery to improve the IW's rehabilitation. Norco is indicated for moderate to moderately severe pain which would be likely following surgery. This request is medically necessary.

**Prospective use of Zanaflex 2mg #20:** Overturned

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

**Decision rationale:** Per ACOEM low back chapter comfort measures are indicated for short term use following surgery to improve the IW's rehabilitation. Zanaflex is a centrally acting alpha2-adrenergic agonist that is FDA approved for management of spasticity; unlabeled use for low back pain which would be likely following surgery. This request is medically necessary.