

Case Number:	CM15-0076145		
Date Assigned:	04/27/2015	Date of Injury:	11/01/2013
Decision Date:	07/03/2015	UR Denial Date:	04/02/2015
Priority:	Standard	Application Received:	04/21/2015

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

Certification(s)/Specialty: Internal Medicine, Pulmonary Disease

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 55 year old male, who sustained an industrial injury on 11/1/2013. He reported pain from his coccyx, around his groin and down to his feet. Diagnoses have included large disc herniation with left lower extremity radiculopathy and progressive neurologic deficit and severe sciatica with large extrusion at L5-S1. Treatment to date has included lumbosacral magnetic resonance imaging (MRI) and medication. According to the progress report dated 2/27/2015, the injured worker complained of constant, severe, low back pain rated 10/10 with radiation to the left lower extremity with associated numbness, tingling, spasms and weakness. He also complained of constant, severe left hip pain rated 10/10 and constant severe left ankle and foot pain rated 10/10. The injured worker ambulated with a single point cane. Physical exam revealed limited range of motion in the lumbar spine. Straight leg raise, Braggard's test and Bowstring's test were all positive to the left. The treatment plan was for a left-sided interlaminar laminotomy and decompression at L5-S1. Authorization was requested for postop physical therapy, Norco, Soma, an off the shelf lumbar brace and a front wheeled walker.

IMR ISSUES, DECISIONS AND RATIONALES

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

Post-op physical therapy totaling 24 visits Lumbar: Upheld

Claims Administrator guideline: Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 26.

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 26.

Decision rationale: The patient is a 55 year old male with an injury on 11/01/2013. He has left L5-S1 lumbar radiculopathy with low back pain radiating to his left lower extremity. He had left straight leg raising and decreased lumbar range of motion. A left L5-S1 laminotomy with decompression has been planned. MTUS, post surgical physical therapy for discectomy/laminectomy (for a more extensive surgery than planned) has a maximum of 16 post operative physical therapy visits and the requested 24 visits is not medically necessary.

Norco Q 4-6 hours PRN #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for use of Opioids. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids On-Going Management Page(s): 78 - 79.

Decision rationale: The patient is a 55 year old male with an injury on 11/01/2013. He has left L5-S1 lumbar radiculopathy with low back pain radiating to his left lower extremity. He had left straight leg raising and decreased lumbar range of motion. A left L5-S1 laminotomy with decompression has been planned. MTUS, chronic pain guidelines for continued treatment with opiates require objective documentation of improved functionality with respect to the ability to do activities of daily living or work and monitoring for efficacy, adverse effects and abnormal drug seeking behavior. The documentation provided for review does not meet these criteria. Therefore, the request is not medically necessary.

Soma 350mg BID #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Carisoprodol (Soma) Page(s): 29.

Decision rationale: The patient is a 55 year old male with an injury on 11/01/2013. He has left L5-S1 lumbar radiculopathy with low back pain radiating to his left lower extremity. He had left straight leg raising and decreased lumbar range of motion. A left L5-S1 laminotomy with decompression has been planned. MTUS, chronic pain guidelines note that muscle relaxants decrease both mental and physical ability. Also, the addition of muscle relaxants to patients already treated with NSAIDS do not improve pain relief. Long-term treatment with muscle relaxants is not consistent with MTUS guidelines and the requested medication is not medically

necessary. Additionally, Carisoprodol is a muscle relaxant that is metabolized to Meprobamate, a controlled substance with a high addiction risk. MTUS guidelines specifically note on page 29 of Chronic Pain guidelines that this medication is not recommended and therefore not medically necessary.

Off the shelf Lumbar brace: 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), Low back - Back brace, post operative (fusion).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300.

Decision rationale: The patient is a 55 year old male with an injury on 11/01/2013. He has left L5-S1 lumbar radiculopathy with low back pain radiating to his left lower extremity. He had left straight leg raising and decreased lumbar range of motion. A left L5-S1 laminotomy with decompression has been planned. MTUS, ACOEM guidelines page 300 note that a lumbar support has no proven efficacy in the treatment of low back symptoms. It is not medically necessary for this patient.

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), Knee & Leg - Walking aids (canes, crutches, braces, orthoses, & walkers).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Cambell's Operative Orthopaedics, 12th Edition.

Decision rationale: The patient is a 55 year old male with an injury on 11/01/2013. He has left L5-S1 lumbar radiculopathy with low back pain radiating to his left lower extremity. He had left straight leg raising and decreased lumbar range of motion. A left L5-S1 laminotomy with decompression has been planned. There is no documentation that the use of a front wheeled walker improves the long-term functional outcome of a laminotomy (hemi-laminectomy). The requested DME is not standard of care and is not medically necessary.