

Case Number:	CM15-0097462		
Date Assigned:	06/01/2015	Date of Injury:	06/12/2001
Decision Date:	07/01/2015	UR Denial Date:	05/13/2015
Priority:	Standard	Application Received:	05/20/2015

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: 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:

This is a 57-year-old male with a June 12, 2001 date of injury. In 2009 he evidently had a L3-4 disc replacement. On 2/7/12, he had a L4-5; L5-S1 lumbar fusion which he states caused severe pain. Follow-up MRI scans are described as showing only disc bulges at L1-2 and L2-3 but documentation does not contain radiologist's reports. Documentation shows provider's discussions regarding one and two level lumbar disc replacements which are not FDA approved. PR2 of 2/25/2015 contains mention of chem analysis positive for THC, benzo, opioids and methamphetamines. A progress note dated April 3, 2015 documents subjective findings (back pain; difficulties with activities of daily living), objective findings (significant pain with twisting of the spine; normal strength, bulk, and tone in all extremities; intact sensation), and current diagnoses (bilateral low back pain without sciatica; degeneration of lumbar or lumbosacral intervertebral disc). Treatments to date have included lumbar injection (pain significantly improved), imaging studies, physical therapy, activity modifications, and medications in addition to the aforementioned operations. The treating physician documented a plan of care that included a pain management evaluation, lumbar laminectomy and fusion, associated surgical services, and medications.

IMR ISSUES, DECISIONS AND RATIONALES

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

Baclofen 10mg #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain) Page(s): 63 and 64.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antispasticity drugs-Baclofen Page(s): 64.

Decision rationale: The California MTUS guidelines recommend baclofen for the treatment of spasticity and muscle spasms related to multiple sclerosis and spinal cord injury. The patient has neither of these. It also has had efficacy in lancinating paroxysmal neuropathic pain. Documentation does not show this to be present. The requested Treatment: Baclofen 10mg #90 is not medically necessary and appropriate.

Buspirone 30mg #60: 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), Pain (Chronic)-Anxiety medications in chronic pain.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Functional restoration approach to chronic pain management; Benzodiazepines Page(s): 7 and 24.

Decision rationale: The California MTUS guidelines recommends the physician have a thorough understanding of the mechanism under lying the patient's pain and choose the pharmacotherapy based on the type of pain treated. Documentation does not disclose why Buspirone was chosen. Buspirone is a non-barbiturate, non-benzodiazepine medication used to treat generalized anxiety disorder. (GAD) Documentation shows no evidence the patient has GAD. The documentation shows the chemical analysis in this patient was positive for benzodiazepines. The California MTUS guidelines note that the appropriate choice of medication to treat an anxiety disorder is an antidepressant. There would not be a medically reasonable indication for the patient to take both a benzodiazepine and Buspirone. The requested treatment: Buspirone 30mg #60 is not medically necessary and appropriate.

Diazepam 10mg #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines Page(s): 24.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines Page(s): 24.

Decision rationale: The California MTUS guidelines do not recommend the long term use of benzodiazepines in the management of chronic pain because long term efficacy is unproven and there is the risk of dependence. The guidelines note that tolerance to anxiolytic effects occurs in

months. The requested treatment: Diazepam 10mg #90 is not medically necessary and appropriate.

Pantoprazole 40mg #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk Page(s): 68.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk Page(s): 68.

Decision rationale: The California MTUS guidelines recommend clinicians should weight the indications for NSAIDs against both GI and cardiovascular risk factors. If the patient is at intermediate risk for gastrointestinal events then a PPI (Proton pump Inhibitor) such as pantoprazole would be reasonable. Documentation does not disclose risk assessment or a history of gastrointestinal events. The requested treatment: Pantoprazole 40mg #3 is not medically necessary and appropriate.

Tizanidine 6mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants, Antispasticity/Antispasmodic drugs Page(s): 66.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antispasticity/Antispasmodic Drugs: Tizanidine Page(s): 66.

Decision rationale: The California MTUS guidelines note that Tizanidine is FDA approved for the management of spasticity. Documentation does not contain information about spasticity as a part of this patient's problems. The guidelines note Tizanidine is unlabeled use for low back pain. The requested treatment: Tizanidine 6mg #60 is not medically necessary and appropriate.

Intermezzo 3.5mg #30: 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), Mental Illness and Stress, Insomnia treatment.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter-insomnia treatment.

Decision rationale: The ODG guidelines recommend the non-Benzodiazepine sedative-hypnotics for short-term treatment with difficulty of sleep onset (7-10) days. Side effects include headaches, daytime drowsiness, dizziness, blurred vision, confusion, abnormal thinking, loss of memory and bizarre behavior. Severe allergic reactions can happen. The requested treatment is for over four weeks and it can be habit forming. The requested treatment: Intermezzo 3.5mg #30 is not medically necessary and appropriate.

Pain management evaluation: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain, Office visits.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 306 and 310.

Decision rationale: The California MTUS guidelines do note that there is moderate research-based evidence for investigating the psychosocial factors in the patient with low back pain. The documentation shows the patient underwent pain management consultation and injections. The documentation does not supply rationale as to why a separate consultation is in order. The guidelines specially do not advise referral for extensive evaluation and treatment prior to exploring the patient's expectations and psychosocial factors. The requested treatment: Pain management evaluation is not medically necessary and appropriate.

Lumbar laminectomy, L3-4, instrumented fusion L3-4 hardware removal: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low back, Hardware implant removal.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-307. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Spinal fusion chapter-Hardware removal.

Decision rationale: The California MTUS guidelines do recommend a spinal fusion for traumatic vertebral fracture, dislocation and instability. This patient has not had any of these events. The guidelines note that the efficacy of fusion in the absence of instability has not been proven. The ODG guidelines do not recommend hardware removal unless it is broken, infected or found to be a pain generator. Documentation does not provide evidence that the hardware is broken, infected or a pain generator. The California MTUS guidelines recommend surgery when the patient has had severe persistent, debilitating lower extremity complaints referable to a specific nerve root or spinal cord level corroborated by clear imaging, clinical examination and electrophysiological studies. Documentation does not provide this evidence. The guidelines note the patient would have failed a trial of conservative therapy. The guidelines note the surgical repair proposed for the lesion must have evidence of efficacy both in the short and long term. The patient states his lumbar fusion of 2/7/12 caused severe pain. The requested treatment: Lumbar laminectomy, L3-4, instrumented fusion L3-4 hardware removal is not 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: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

Associated Surgical Service: 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.

Associated Surgical Service: EKG: 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.

Preoperative labs: 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.

Two day inpatient hospital stay: 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.

Morphine 60mg #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 78.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines oral morphine Page(s): 96.

Decision rationale: The California MTUS guidelines do not recommend oral morphine as a primary treatment of persistent pain. They note that the use of opioid analgesics for chronic non-cancer pain is controversial. They noted one randomized controlled trial may confer analgesic benefit but were unlikely to yield psychological or functional improvement. The requested treatment: Morphine 60mg #90 is not medically necessary and appropriate.