

MAXIMUS FEDERAL SERVICES, INC.

Independent Medical Review

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Notice of Independent Medical Review Determination

Dated: 11/27/2013

[REDACTED]

[REDACTED]

Employee:	[REDACTED]
Claim Number:	[REDACTED]
Date of UR Decision:	7/10/2013
Date of Injury:	3/14/2012
IMR Application Received:	7/29/2013
MAXIMUS Case Number:	CM13-0004517

- 1) MAXIMUS Federal Services, Inc. has determined the request for **anterior and posterior discectomy, decompression and fusion w/instrumentation-L4-5, L5-S1 is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for **post-op PT 3 times a week for 4 weeks is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for **retro drug screen for PAC pain panel is not medically necessary and appropriate.**

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 7/29/2013 disputing the Utilization Review Denial dated 7/10/2013. A Notice of Assignment and Request for Information was provided to the above parties on 8/8/2013. A decision has been made for each of the treatment and/or services that were in dispute:

- 1) MAXIMUS Federal Services, Inc. has determined the request for **anterior and posterior discectomy, decompression and fusion w/instrumentation-L4-5, L5-S1** is not **medically necessary and appropriate**.
- 2) MAXIMUS Federal Services, Inc. has determined the request for **post-op PT 3 times a week for 4 weeks** is not **medically necessary and appropriate**.
- 3) MAXIMUS Federal Services, Inc. has determined the request for **retro drug screen for PAC pain panel** is not **medically necessary and appropriate**.

Medical Qualifications of the Expert Reviewer:

The independent Medical Doctor who made the decision has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Orthopedic Surgery, and is licensed to practice in California. 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 treatments and/or services at issue.

Expert Reviewer Case Summary:

The patient is a 51-year-old male who reported an injury on 04/14/2012, when he fell landing backwards on his buttocks. He is noted to have had a work-related injury to his low back in 2009 and to have undergone a microdiscectomy and recovered within a week or 2 and was back at work. The patient is reported to have been working full time up to 15 hours a day with no restrictions and no complaints of pain. He is reported to complain of ongoing low back pain with radiation of pain to his left leg, restrictions of range of motion, an absent Achilles reflex on the left, and decreased strength of the left lower extremity and ankle flexion. The patient is reported to have treated conservatively with lumbar epidural steroid injections, short term relief of pain, medications, and a trigger point injection. He is reported to have undergone an electrodiagnostic study on 06/21/2012, which is reported to show an acute left S1 radiculopathy. He is reported to have undergone an MRI of the lumbar spine on 03/30/2012, which was reported to reveal a large 10 mm by 8 mm by 9 mm left posterolateral disc extrusion compressing the traversing left L5 nerve root. The patient is noted to have received trigger point injections. On 04/16/2013, Dr. [REDACTED] reported the patient continued to complain of low back pain with radiating pain to his legs with weakness and tingling in his lower extremity. He is noted to have not responded to conservative treatment with physical therapy, chiropractic care, acupuncture, anti-inflammatory medications, and epidural steroid injections.

The patient is noted to have perimuscular tenderness, decreased range of motion, and weakness as well as decreased sensation in the lower extremities consistent with the disc desiccation protrusion and nerve root impingement shown on the MRI. The patient was recommended for an anterior and posterior discectomy decompression and fusion. The physician stated by doing a posterior decompression, there was potential for instability. Therefore, a fusion was indicated.

Patient with a history of debilitating pain due to a disc bulge at L5-S1 had undergone microdiscectomy in JUNE 2009. PATIENT SUFFERED FROM POST LAMINECTOMY SYNDROME. He subsequently received epidural steroid injections in 2012 which provided 60% relief. He received oral analgesic medications including OxyContin as well as Percocet.

On exam dated March 6, 2013 the patient received Anaprox, Prilosec, OxyContin and Percocet for pain. Is to be noted that narcotic pain medications have been given for several months. Other such medications included Norco. He was determined to have chronic myofascial pain in the lumbar musculature. Toradol injections were given the right buttocks for pain management as well.

Documents Reviewed for Determination:

The following relevant documents received from the interested parties and the documents provided with the application were reviewed and considered. These documents included:

- Application of Independent Medical Review
- Utilization Review Determination
- Medical Records from Employee/Employee Representative
- Medical Treatment Utilization Schedule (MTUS)

1) Regarding the request for anterior and posterior discectomy, decompression and fusion w/instrumentation-L4-5, L5-S1:

The Medical Treatment Guidelines Relied Upon by the Expert Reviewer to Make His/Her Decision

The Claims Administrator based its decision on the CA MTUS ACOEM Guidelines, pg. 310, which is a part of the MTUS. Also cited was the Official Disability Guidelines: Low Back Chapter, which is not a part of the MTUS.

The Expert Reviewer based his/her decision on the Low Back Complaints (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 12) Surgical Considerations.

Rationale for the Decision:

A request was submitted for a lumbar anterior posterior discectomy decompression and fusion with instrumentation at L4-5 through S1. The California MTUS Guidelines recommend a lumbar discectomy for patients with severe disabling leg symptoms in a distribution consistent with abnormalities on imaging studies and with accompanying objective findings of neural compression when there is clear imaging and neurophysiological evidence of a lesion that is shown to benefit in the long term and short term from surgical repair after failure of conservative treatment to resolve disabling radicular symptoms and recommend a lumbar direct nerve root decompression including laminectomy or standard discectomy or laminotomy. The California MTUS guides state that except for in cases of trauma-related spinal fractures or dislocations, fusions are not usually considered except for patient with increased spinal instability after surgical decompression at the level of degenerative spondylosis may be candidates for fusion. After a review of the medical records provided, the employee is reported to have findings of radiculopathy that are consistent with the imaging studies, including an MRI reported to have been performed on 03/30/2012. However, as the imaging studies were not submitted for review, the need for a lumbar decompression at L4-5 and L5-S1 could not be established. As the employee is not noted to have a fracture or dislocation in the lumbar spine or to have increased spinal instability, and is not noted to be undergoing a decompression for degenerative spondylolisthesis, the request for a spinal fusion does not meet guideline recommendations. **The request for anterior and posterior discectomy, decompression and fusion with instrumentation at L4-5 and L5-S1 is not medically necessary and appropriate.**

2) Regarding the request for post-op PT 3 times a week for 4 weeks:

The Medical Treatment Guidelines Relied Upon by the Expert Reviewer to Make His/Her Decision

Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

3) Regarding the request for retro drug screen for PAC pain panel:

The Medical Treatment Guidelines Relied Upon by the Expert Reviewer to Make His/Her Decision

The Claims Administrator based its decision on the CA MTUS, ODG.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Opioids, Steps to avoid misuse/addiction, pages 94-95, which are a part of the MTUS and the Official Disability Guidelines (ODG) (online version), Pain (Chronic) Chapter, Urine drug testing, which is not part of the MTUS.

Rationale for the Decision:

The employee reported an injury to the low back on 04/14/2012. The medical records review note a previous non-work-related injury to the low back in 2009 and a microdiscectomy at left L5-S1. The employee recovered within a week or two and returned to work with no further low back pain or radicular pain noted until a fall in 04/2012. The medical records document complaints of ongoing low back pain with radiation of pain to his left lower extremity. Physical exam notes restrictions of range of motion and absent Achilles reflex on the left and decreased strength of the left lower extremity in ankle flexion. The employee is reported to have been treated conservatively with lumbar epidural steroid injections with short-term relief of pain, trigger point injections, and to have undergone electrodiagnostic studies. An MRI reported a large left-sided posterolateral disc extrusion compressing the left L5 nerve root and an acute left L5 radiculopathy on electrodiagnostic studies were noted. The employee is reported to be taking OxyContin 40 mg 3 times a day as needed and Percocet 10/325 mg 6 tablets per day for pain. The California MTUS Guidelines recommend frequent random urine toxicology screens as a step to avoid misuse of opioids, in particular for those at high risk of abuse. However, the Official Disability Guidelines state that confirmatory testing is only recommended if a point of care screen shows other drugs other than the patient's prescribed drugs, and does not recommend the use of quantitative urine drug testing to verify compliance without evidence of necessity. As such, a point of care drug screen would be indicated as the employee is receiving opioid narcotics for complaints of pain. However, the need for a confirmatory drug screen or a quantitative urine drug screen test is not established, as there is no documentation that the employee's point of care drug screen showed evidence of non-prescribed narcotic analgesics or other drugs that were not prescribed, and there is no documentation of medical necessity for a quantitative urine drug screen. **The request for a retro drug screen for PAC pain panel is not medically necessary and appropriate.**

Effect of the Decision:

The determination of MAXIMUS Federal Services and its physician reviewer is deemed to be the final determination of the Administrative Director, Division of Workers' Compensation. With respect to the medical necessity of the treatment in dispute, this determination is binding on all parties.

In accordance with California Labor Code Section 4610.6(h), a determination of the administrative director may be reviewed only if a verified appeal is filed with the appeals board for hearing and served on all interested parties within 30 days of the date of mailing of the determination to the employee or the employer. The determination of the administrative director shall be presumed to be correct and shall be set aside only upon proof by clear and convincing evidence of one or more of the grounds for appeal listed in Labor Code Section 4610.6(h)(1) through (5).

Sincerely,

Paul Manchester, MD, MPH
Medical Director

cc: Department of Industrial Relations
Division of Workers' Compensation
1515 Clay Street, 18th Floor
Oakland, CA 94612

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Disclaimer: MAXIMUS is providing an independent review service under contract with the California Department of Industrial Relations. MAXIMUS is not engaged in the practice of law or medicine. Decisions about the use or nonuse of health care services and treatments are the sole responsibility of the patient and the patient's physician. MAXIMUS is not liable for any consequences arising from these decisions.