

<b>Case Number:</b>	CM13-0047291		
<b>Date Assigned:</b>	12/27/2013	<b>Date of Injury:</b>	09/17/2004
<b>Decision Date:</b>	08/11/2014	<b>UR Denial Date:</b>	10/30/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/01/2013

### 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. The expert reviewer is Board Certified in Physical Medicine and Rehabilitation, has a subspecialty in Interventional Spine 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 disputed items/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### 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 patient is a 44-year-old female with a date of injury of 09/17/2004. The listed diagnoses per [REDACTED] are status post lumbar disk herniation with decompression with adjacent-level syndrome at L4 to L5, left hip trochanteric bursitis, left leg tendinosis, thoracic disk bulging with cord impingement at T7 to T8, bilateral lumbar neuralgia with facet arthropathy, depression with sleep disorder, status post lumbar fusion with L5 to S1 with hardware failure and anxiety, sleep disorder. This patient is status post lumbar spine fusion at the L5 to S1 level on 11/20/2005. The patient presents with occasional left knee pain and occasional buckling of the knee. Revision back surgery is under review. Medications include Methadone 10 mg, Klonopin 0.5 mg, Zanaflex, Flector patches, Adderall, Cymbalta, phentermine, and ibuprofen 800 mg. An examination of the lumbar spine revealed decreased range of motion in all planes. Examination of the lumbar and thoracic spine revealed degenerative changes with facet arthropathy extensively through the L2 to S1 regions. Examination of the lower extremity revealed tenderness and spasm to the lower thoracic and complete lumbar region. Paravertebral spasm is present bilaterally to the lower back and into the buttocks. There is sciatic notch tenderness, specifically on the right. Straight leg raise is positive 15 degrees on the right and 30 degrees on the left. There is pain at the left anterior groin consistent with trochanteric bursitis and left hip muscles/labral tear. The provider is recommending evaluation of the lower back with an MRI study. The request is for magnetic resonance (e.g. proton) imaging, spinal canal and contents, without contrast material; magnetic resonance (e.g. proton) imaging, any joint of lower extremity, without contrast material; Terocin cream; reevaluation with [REDACTED]. Utilization review denied the request on 10/30/2013.

## IMR ISSUES, DECISIONS AND RATIONALES

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

### **MAGNETIC RESONANCE (EG, PROTON) IMAGING, ANY JOINT OF LOWER EXTREMITY; WITHOUT CONTRAST MATERIAL: Upheld**

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

**MAXIMUS guideline:** The Expert Reviewer based his/her decision on the MTUS ACOEM Practice Guidelines, Chapter 12 Low Back Complaints, Page 303 and on the Non-MTUS Official Disability Guidelines (ODG).

**Decision rationale:** This patient is status post lumbar L5 to S1 fusion in 2005. MRI of the lumbar spine from 09/08/2011 demonstrated compared with the prior CT of the lumbar spine dated 12/09/2006. There appears to be no significant interval changes. MRI of the thoracic spine performed on 09/08/2011 demonstrated right-sided posterolateral osteophytes noted at T9 to T10 and T10 and T11 levels with associated mild to moderate narrowing of the right T9 and right T10 neuroforamina. A 3-mm right-sided disk protrusion noted at the T7 to T8 level. EMG of the lower extremity performed on 10/05/2011 was normal. Lumbar x-rays from 05/03/2012 demonstrated status post bilateral posterolateral anterior interbody fusion at L5 to S1, no evidence of lumbar instability, moderate to severe degenerative disk space narrowing, degenerative facet changes at the lower 3 lumbar levels, no acute abnormalities. In this case, it appears the patient has had prior MRI and x-ray imaging. Review of the progress report does not indicate the patient has any significant change in subjective and objective findings to warrant further investigation. Therefore the request is not medically necessary.

### **MAGNETIC RESONANCE (EG, PROTON) IMAGING, SPINAL CANAL AND CONTENTS, WITHOUT CONTRAST MATERIAL: Upheld**

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

**MAXIMUS guideline:** The Expert Reviewer based his/her decision on the MTUS ACOEM Practice Guidelines, Chapter 12, Low Back Complaints, Page 303 and on the Non-MTUS Official Disability Guidelines (ODG) Low Back.

**Decision rationale:** This patient is status post lumbar L5 to S1 fusion in 2005. MRI of the lumbar spine from 09/08/2011 demonstrated compared with the prior CT of the lumbar spine dated 12/09/2006. There appears to be no significant interval changes. MRI of the thoracic spine performed on 09/08/2011 demonstrated right-sided posterolateral osteophyte noted at T9 to T10 and T10 and T11 levels with associated mild to moderate narrowing of the right T9 and right T10 neuroforamina. A 3-mm right-sided disk protrusion noted at the T7 to T8 level. EMG of the lower extremity performed on 10/05/2011 was normal. Lumbar x-rays from 05/03/2012 demonstrated status post bilateral posterolateral anterior interbody fusion at L5 to S1, no evidence of lumbar instability, moderate to severe degenerative disk space narrowing, degenerative facet changes at the lower 3 lumbar levels, no acute abnormalities. ACOEM Guidelines page 303 states unequivocal objective findings that identify specific nerve compromise on the neurological examination is sufficient evidence to warrant imaging in patients who do not respond well to treatment and who would consider surgery as an option.

When the neurologic examination is less clear, however, further physiologic evidence of nerve dysfunction should be obtained before ordering an imaging study. In this case, the provider would like an updated MRI for increased symptoms. However, there are no new injuries, no significant changes in examination, no bowel/bladder symptoms, no new location of symptoms requiring additional investigation. Therefore the request is not medically necessary.

**TEROCIN CREAM:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111.

**Decision rationale:** This patient is status post lumbar L5 to S1 fusion in 2005 and has continued low back and lower extremities pain. The provider is requesting a refill of Terocin Lotion 120ml. Terocin topical cream contains capsaicin, methyl salicylate, menthol, and Lidocaine. The California MTUS Guidelines p 111 has the following regarding topical creams, topical analgesics are largely experimental and used with few randomized control trials to determine efficacy or safety. California MTUS further states, any compounded product that contains at least one (or drug class) that is not recommended is not recommended. Per California MTUS, Lidocaine is only allowed in a patch form and not allowed in cream, lotion or gel forms. Therefore the request is not medically necessary.

**RE-EVALUATION WITH [REDACTED]:** Overturned

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 5 Cornerstones of Disability Prevention and Management Page(s): 92.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 7, page 127.

**Decision rationale:** This patient is status post lumbar L5 to S1 fusion in 2005 and has continued low back and lower extremities pain. The provider is requesting a re-evaluation for surgical opinion with [REDACTED]. Utilization review denied the requesting stating, the patient has been approved for a HELP program evaluation and it does not appear she is a surgical candidate. ACOEM Practice Guidelines second edition (2004) page 127 has the following: The occupational health practitioner may refer to other specialist if a diagnosis is uncertain or extremely complex, when psychosocial factors are present, or when the plan or course of care may benefit from additional expertise. ACOEM Guidelines further states referral to a specialist is recommended in complex issues. In this case, the provider has concerns of patient's complaints of low back and lower extremity radicular pain. A re-evaluation for possible surgical intervention is reasonable. Therefore the request is medically necessary.