

<b>Case Number:</b>	CM13-0057888		
<b>Date Assigned:</b>	09/03/2014	<b>Date of Injury:</b>	06/07/2010
<b>Decision Date:</b>	10/03/2014	<b>UR Denial Date:</b>	11/25/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/25/2013

### 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 Orthopedic Surgery and is licensed to practice in Texas. 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 injured worker is a 43-year-old male, who reported injury on 06/07/2010. The specific mechanism of injury was the injured worker was bent over a rail dock when his right knee buckled causing him to fall. The prior therapies included an epidural steroid injection and physical therapy. The prior surgical intervention included a right knee arthroscopic surgery on 08/19/2010. The diagnostic studies included an x-ray of the bilateral knees and an MRI of the lumbar spine. The injured worker underwent an MRI of the lumbar spine on 05/29/2012, which revealed there were mild degenerative changes and a mildly congenitally narrowed spinal canal with short pedicles, as described. At L5-S1, there was a very small 3 mm broad based left paracentral disc protrusion with an annular fissure without significant canal stenosis. There was mild left sided neural foraminal stenosis without significant right sided neural foraminal stenosis. There was a mildly congenitally narrowed spinal canal, L2-5. There was no high grade spinal canal stenosis or high grade neural foraminal stenosis. The short pedicles were noted to be at L2-3 and L3-4. Prior therapies included an epidural steroid injection. The documentation of 05/12/2013 revealed the injured worker had chronic low back pain. The injured worker had lower extremity radicular pain. The injured worker's medications were noted to include Axid, Protonix, Gaviscon, and Carafate. The physical examination revealed a positive straight leg raise on the right and a positive Lasegue's sign. There was a motor deficit at L5 on the right side with extensor hallucis weakness rated at 3/5. The injured worker was unable to heel and toe walk. There were moderately diffuse lumbar paraspinal muscle spasms. The Valsalva maneuver produced discomfort. The range of motion was decreased. There was tenderness to palpation over the midline of L5-S1 as well as over the bilateral lumbar facet joints at L5-S1 and L4-5 levels, right greater than left. The injured worker was a non-smoker. The diagnoses included annular tear at L5-S1, lumbar herniated nucleus pulposus L5-S1, chronic low back pain, failure

of conservative treatment, and morbid obesity. The discussion and treatment plan included, as the injured worker had failed conservative care and was not a candidate for further pain management injections, the injured worker would be a candidate for a lumbosacral fusion anteriorly and posteriorly at L5-S1. The injured worker underwent an MRI of the left knee on 12/12/2013, which revealed intrasubstance mucoïd signal within the posterior horns of the medial and lateral menisci with no definite evidence of a meniscal tear. There was mild chondromalacia at the outer edge of the patella, and there was a 4 mm osteochondral lesion at the anterior intercondylar surface of the femur. The documentation indicated the injured worker had a knee brace. There was a Request for Authorization form dated 12/30/2013 for the cyclobenzaprine cream. The physician documentation of the same date indicated it was being prescribed for chronic pain. Additional diagnoses included left knee internal derangement. There was a Request for Authorization for a left knee brace and an interferential unit on 12/11/2013. The documentation was handwritten and difficult to read. The legible part indicated the injured worker would be helped with an interferential unit and a hinged knee brace. There was no Request for Authorization made for the surgical intervention and the accompanying ancillary services.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

#### **Anterior and Posterior Lumbar fusion: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): page 307. Decision based on Non-MTUS Citation Official Disability Guidelines Indications for surgery - Discectomy

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-307.

**Decision rationale:** The American College of Occupational and Environmental Medicine indicate a surgical consultation may be appropriate for injured workers who have severe and disabling lower leg symptoms in a distribution consistent with abnormalities on imaging studies preferably with accompanying objective signs of neural compromise. There should be documentation of activity limitations due to radiating leg pain for more than 1 month or the extreme progression of lower leg symptoms, and clear clinical, imaging and electrophysiologic evidence of a lesion that has been shown to benefit in both the short and long term from surgical repair and documentation of a failure of conservative treatment to resolve disabling radicular symptoms. There is no good evidence from controlled trials that spinal fusion alone is effective for treating any type of acute low back problem, in the absence of spinal fracture, dislocation, or spondylolisthesis if there is instability and motion in the segment operated on. Electrodiagnostic studies would not be necessary for consideration of a fusion surgery. The injured worker had a motor deficit at L5 and was noted to have failed conservative care. The injured worker underwent an MRI that revealed a mild left sided neural foraminal stenosis without significant right sided neural foraminal stenosis. There was no evidence of significant spinal canal stenosis. There was a lack of documentation of findings of instability through flexion and extension x-rays of the lumbar spine. The physician documentation was requesting a lumbosacral fusion

anteriorly and posteriorly at L5-S1. However, the request as submitted failed to indicate the level for the requested surgery. Given the above, the request for anterior and posterior lumbar fusion is not medically necessary.

**Commode 3 in 1:** 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.

**Lumbar Sacral Orthosis:** 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.

**Pneumatic Compressor, non-segmental home model:** 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.

**Segmental gradient pressure pneumatic appliance half leg:** 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:** As the requested surgical intervention is not supported by the documentation, the requested ancillary service is also not supported.

**Walker:** 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.

**Graft Instrumentation neuromonitoring:** 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.

**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.

**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.

**Post-Operative Home Health Evaluation:** 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.

**Vascular Consult:** 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.

**Post Operative Physical Therapy 12 sessions:** 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:** As the requested surgical intervention is not supported by the documentation, the requested ancillary service is also not supported.

**Cyclobenzaprine cream 60gm with 1 refill:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesic, Muscle Relaxants Page(s): 41, 64.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics, Cyclobenzaprine Page(s): 41.

**Decision rationale:** The California MTUS guidelines indicates that topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety...topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed...Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. The addition of Cyclobenzaprine to other agents is not recommended. They do not recommend the topical use of Cyclobenzaprine as topical muscle relaxants as there is no evidence for use of any other muscle relaxant as a topical product. There was a lack of documentation of a failure of antidepressants and anticonvulsants. The duration of use could not be established through supplied documentation. There was a lack of documentation indicating a necessity for 1 refill without re-evaluation. The request as submitted failed to indicate the frequency for the requested medication. The clinical documentation submitted for review failed to provide documentation of exceptional factors to warrant not adhering to guideline recommendations. Given the above, the request for Cyclobenzaprine cream 60gm with one refill is not medically necessary.

**IF Unit:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 118-120.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation Page(s): 118.

**Decision rationale:** The California MTUS Guidelines do not recommend interferential current stimulation as a standalone treatment. There was a lack of documentation indicating the injured worker would be utilizing the interferential unit as an adjunct to other therapies. The request as submitted failed to indicate whether the request was for rental or purchase. Given the above, the request for IF Unit is not medically necessary.

**Brace Left Knee Hinged:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 346.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 346.

**Decision rationale:** The American College of Occupational and Environmental Medicine indicate a brace can be used for patellar instability, anterior cruciate ligament tear, or medial collateral ligament instability. It is usually only necessary if the injured worker is going to be stressing the knee under load, such as climbing ladders or carrying boxes. The clinical documentation submitted for review failed to provide a rationale for the requested service. Additionally, it was indicated the injured worker had a prior brace and there was a lack of documentation indicating whether the brace was for the left knee or the right knee or both. Given the above and the lack of clarification, the request for Brace Left Knee Hinged is not medically necessary.