

<b>Case Number:</b>	CM13-0059237		
<b>Date Assigned:</b>	12/30/2013	<b>Date of Injury:</b>	10/23/2008
<b>Decision Date:</b>	04/25/2014	<b>UR Denial Date:</b>	11/21/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/02/2013

### 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 Pennsylvania. 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 45-year-old female with a reported injury date of October 23, 2008. The records suggest diagnoses of a grade I spondylolisthesis at L5-S1 and a history of bilateral lower extremity radiculopathy. However, electrodiagnostic studies of June 2009 were negative for radiculopathy. Repeat electrodiagnostic studies in January of 2012 were also negative for lumbar radiculopathy. Exam has been reported to show 4/5 strength for the tibialis anterior, extensor hallucis longus (EHL) and gastrocnemius soleus complex bilaterally. Lower extremity sensation is normal and reflexes were 2+ and symmetric. The most recent MRI performed August 2, 2013 showed a left lateral disc protrusion at L3-4 impinging on the left L4 nerve root. An L5-S1 small protrusion with facet hypertrophy is noted to cause bilateral compression of the L5 nerve roots. Records indicate the patient received conservative treatment with epidural steroid injection, modified activity, medications and physical therapy. Current request is for an L5-S1 fusion and an L3-4 discectomy. Requests are also made for thirty-six sessions of postoperative therapy, transportation to the hospital, two-day stay, vascular surgery consult and a hospital bed for 30 days. Medication requests include flurbiprofen gel and Medrox patches.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**ANTERIOR POSTERIOR FUSION AND DECOMPRESSION AT L5-S1 AND DISCECTOMY AT L3-L4: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-307, 310.

**Decision rationale:** The California MTUS ACOEM Guidelines do not generally support lumbar fusion in the absence of instability. Lumbar decompression or discectomy at the involved levels may be reasonable based on the failure of conservative care and the pathology noted on MRI, but the fusion would not be regarded as medically necessary unless there is radiological support for the reported spondylolisthesis. There is no indication from the records reviewed that the patient has undergone flexion/extension studies to evaluate for dynamic instability. Therefore, the request is non-certified.

**TWO (2) NIGHTS INPATIENT HOSPITALIZATION:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Low Back, Hospital Length of Stay

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Milliman Care Guidelines; 18th Edition; Inpatient and Surgical length of Stay

**Decision rationale:** The associated two-day stay would not be regarded as medically necessary as the proposed surgery for an anterior posterior fusion and decompression at L5-S1 and discectomy at L3-L4 cannot be recommended as medically necessary.

**POSTOPERATIVE REHABILITATIVE PHYSICAL THERAPY TO THE LUMBAR SPINE, TOTALING 36 VISITS FOR POST-SURGICAL TREATMENT:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Postsurgical Treatment Guidelines.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Post-Surgical Treatment Guidelines, Surgery: Lumbar: Post-Surgical treatment fusion

**Decision rationale:** The Anterior posterior fusion and decompression at L5-S1 and discectomy at L3-L4 cannot be recommended as medically necessary. Therefore, the request for postoperative therapy would not be regarded as medically necessary.

**VASCULAR SURGEON:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Milliman Care Guidelines; 18th Edition; Assistant Surgeon

**Decision rationale:** The associated vascular surgery consult would not be regarded as medically necessary as the anterior posterior fusion and decompression at L5-S1 and discectomy at L3-L4 cannot be recommended as medically necessary.

**HOSPITAL BED RENTAL FOR 30 DAYS:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Aetna Clinical Policy Bulletin: Hospital Beds and Accessories

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chapter Knee and Leg: Durable Medical Equipment

**Decision rationale:** The associated hospital bed would not be regarded as medically necessary given the failure to prove the medical necessity of the requested surgical procedure.

**TRANSPORTATION TO AND FROM THE FACILITY:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Department of Health Care Services-California

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chapter Knee and Leg: Transportation to and from appointments

**Decision rationale:** The associated transportation would not be regarded as medically necessary given the failure to prove the medical necessity of the requested surgical procedure.

**MEDROX PATCHES, #30:** 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): 111-112.

**Decision rationale:** The use of Medrox gel cannot be recommended as medically necessary. Medrox gel includes methyl salicylate, menthol and Capsaicin in a topical preparation. The California MTUS Guidelines recommend Capsaicin only as an option in patients who have not responded to other treatments or who are intolerant to other treatments. In addition, the 0.05% formulation of Capsaicin included in the Medrox gel has no studies regarding efficacy for back

pain and Chronic Pain Guidelines indicate that it should be considered experimental in very high doses beyond the typical formulation of 0.025%. For these reasons, the Medrox gel cannot be recommended as medically necessary.

**FLURBIPROFEN 20% GEL, 120GM:** 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): 111-112.

**Decision rationale:** The use of topical flurbiprofen anti-inflammatory gel cannot be recommended as medically necessary. The California MTUS Chronic Pain 2009 Guidelines may support topical anti-inflammatory medications for knee osteoarthritis, but would not support topical use in this setting for lower back pain and potential radiculopathy. Therefore, the request is non-certified.