

Case Number:	CM13-0068446		
Date Assigned:	01/03/2014	Date of Injury:	10/23/2008
Decision Date:	04/09/2014	UR Denial Date:	12/10/2013
Priority:	Standard	Application Received:	12/19/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Orthopedic Surgeon 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 physician 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 who was injured on 10/23/2008 while performing her usual and customary job duties walking to the break room at her work place then she suddenly slipped on water that had been spilled on the floor which aggravated her low back symptoms. Treatment history included patient has a past medical history of hypothyroidism which is controlled with medications. Norco. Diagnostic studies reviewed include MRI of the lumbar spine dated 01/10/2012 revealing left-sided recurrent chronic sciatica with 2-3 mm far left lateral disc bulge at L4-5 and peripheral annular fissure. X-rays of the lumbar spine dated 05/03/2013 reveals a grade I spondylolisthesis at L5-S1. Orthopedic consultation note dated 05/03/2013 documented the patient to have complaints of continuous pain in the lower back and the pain is present 70% of the time. The pain level in the lumbar spine is level 8. Her pain level becomes worse in the evenings. She has heat and medications to alleviate the pain. Progress report PR-2 dated 06/07/2013 indicates that the patient is documented with complaints of constant low back pain rated as a 6/10 radiating into the bilateral lower management, which she states helps to alleviate her symptoms. Objective findings on exam include paraspinal spasms and tenderness. Positive straight leg raise on the right at 40 degrees. Lower extremity motor strength is 5/5 bilaterally in the iliopsoas and quadriceps muscle groups except for weakness in the bilateral tibialis anterior, EHL, gastroc and peroneus longus at 4/5. Diagnoses: 1) Grade I spondylolithiasis at L5-S1 with bilateral lower extremity radiculopathy. 2) Status post bilateral carpal tunnel release with residuals. Progress report PR-2 dated 08/02/2013 is the same as 06/07/2013 exam above. Note: UR decision dated 12/09/2013 certified the request for anterior and posterior fusion and decompression at L5-S1 and discectomy at L3-4.

IMR ISSUES, DECISIONS AND RATIONALES

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

Flurbiprofen 20% gel, 120gm: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113.

Decision rationale: As per CA MTUS guidelines, topical NSAIDs including Flurbiprofen has not been evaluated to topical treatment of the spine, hip or shoulder. In this case, this patient is certified for anterior and posterior fusion and decompression at L5-S1 and discectomy at L3-4 and the provider has requested for treatment of lumbar spine. Thus, the request for Flurbiprofen 20% gel, 120 gm is not medically necessary and is non-certified.

Medrox patches #30: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113.

Decision rationale: Medrox patch consists of 5% methyl salicylate, 5% menthol and 0.0375% capsaicin. As per CA MTUS guidelines, capsaicin is generally available as a 0.025% formulation. There have been no studies of a 0.0375% formulation of capsaicin and there is no current indication that this increase over a 0.025% formulation would provide any further efficacy. The dosage of capsaicin in the Medrox patch exceeds guidelines recommendation. Further guidelines indicate that any compounded product that recommended. Thus, the request for Medrox patches #30 is non-certified.

Transportation to and from the Facility: 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 Official Disability Guidelines (ODG), Knee & Leg (Acute & Chronic), Transportation (to & from appointments).

Decision rationale: CA MTUS guidelines do not discuss the request in dispute and hence ODG have been consulted. As per ODG, "recommended for medically-necessary transportation to appointments in the same community for patients with disabilities preventing them from self-transport." The records submitted for review has no documentation why this patient needs the transportation to and from the facility. It is unclear if this patient lives alone or does not have any

family member or friends who can provide the need for transportation. Thus, the medical necessity has not been established and the request is non-certified.

Hospital Bed Rental for (30) days: 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 <http://www.cms.gov/medicare-coverage-database/details/ncd-details.aspx?NCDId=227&ncdver=1&DocID=280.7&SearchType=Advanced&bc=IAAAA BAAAAAA&>

Decision rationale: CA MTUS guidelines and ODG do not discuss the issue in dispute and hence other evidence based guidelines have been consulted. As per the referenced guidelines, "The physician's prescription, which must accompany the initial claim, and supplementing documentation when required, must establish that a hospital bed is medically necessary. If the stated reason for the need for a hospital bed is the patient's condition requires positioning, the prescription or other documentation must describe the medical condition, e.g., cardiac disease, chronic obstructive pulmonary disease, quadriplegia or paraplegia, and also the severity and frequency of the symptoms of the condition that necessitates a hospital bed for positioning. If the stated reason for requiring a hospital bed is the patient's condition requires special attachments, the prescription must describe the patient's condition and specify the attachments that require a hospital bed." In this case, this patient has not had surgery yet and it is not certain that this patient will have difficulties or complications from the surgery that will require positioning. There is will be required. Thus, the medical necessity has not been established and the request is non-certified.

Pre-Surgical Internal Medicine Evaluation and Clearance: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACC/AHA 2007 Guidelines on Perioperative Cardiovascular Evaluation and Care for Noncardiac Surgery, (<http://circ.ahajournals.org/cgi/content/full/116/17e418>).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back - Lumbar & Thoracic (Acute and Chronic), Preoperative electrocardiogram (ECG), Preoperative lab testing, Preoperative testing, general

Decision rationale: CA MTUS guidelines state that the occupational health practitioner may refer to other specialists 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. This patient is certified for a major surgery of anterior and posterior fusion and decompression at L5-S1 and discectomy at L3-4 that requires preoperative clearance and to minimize risk of the

surgery and hence the request for pre-surgical internal medicine evaluation and clearance is certified.

Post-Operative Physical Therapy to the Lumbar Spine, totaling (36) visits for post-surgical treatment: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation National Guideline Clearinghouse(http://guideline.gov/summary/.aspx?doc_id+12973&nbr=006682)

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 26.

Decision rationale: CA MTUS guidelines recommend post-operative physical therapy of 34 visits over 16 weeks for fusion and 16 visits for discectomy and laminectomy. The provider has requested 36 visits of post-operative therapy to the lumbar spine which exceeds the guidelines recommendation and hence the request is non-certified