

<b>Case Number:</b>	CM14-0001182		
<b>Date Assigned:</b>	01/22/2014	<b>Date of Injury:</b>	10/14/2009
<b>Decision Date:</b>	06/20/2014	<b>UR Denial Date:</b>	12/06/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/03/2014

### 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, has a subspecialty in Spine 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 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 54-year-old male who reported an injury on 10/14/2009. The mechanism of injury was the injured worker was lifting a box of paperwork weighing approximately 30 to 40 pounds from the ground to the table when he felt a sharp pain in the low back. The injured worker underwent an MRI (magnetic resonance imaging) of the lumbar spine which revealed at L2-3 there was a mild anterior disc protrusion in plate osteophyte complex and a Modic type 1 signal change in the anterior superior L3 vertebral body. At L3-4 there was a 2 mm left paracentral posterior disc protrusion with left foraminal extension abutting the thecal sac and the left L4 nerve root in the left lateral recess. There was left facet arthropathy. There was mild neural foraminal stenosis and mild left lateral recess stenosis. At L4-5 there was a 3 mm central posterior disc protrusion with bilateral paracentral extension abutting both L5 nerve roots in both lateral recesses. There was facet arthropathy. There was mild lateral recess stenosis. Additionally, a transitional vertebra noted at L5. Nomenclature was ambiguous and the physician opined we will assume that the last hydrated intervertebral disc of normal size was present at L5-S1. If surgery was contemplated, there was a suggestion of correlation with plain films of the spine. There was left L5 hemisacralization noted. The documentation of 10/21/2013 revealed a secondary treating physician's comprehensive orthopedic consultation and report. The injured worker underwent prior treatments including physical therapy. The injured worker underwent medications and epidural injections. The injections relieved the pain temporarily for one month. The current medications as of 10/21/2013 revealed the injured worker was utilizing topical cream medications; however, those cream medications were not provided. The injured worker additionally was taking Tramadol and diclofenac as well as melatonin. The injured worker's symptoms included intermittent pain in the back with radiation to the bilateral lower extremities, right greater than left. Pain was present 50% of the time. The injured worker

indicated that he had episodes of numbness and tingling in the right lower extremity. The injured worker indicated that on a bad day, pain increased to 7/10 and on a good day it was 5/10. The injured worker was unable to sit for more than 30 minutes or stand for more than 2 hours before pain symptoms increased. The physical examination revealed paraspinal spasms and tenderness to palpation over L3-4 and L4-5 with radiating pain into the lower extremities. Lumbar range of motion was limited. The injured worker had a positive straight leg raise test. The sensory examination revealed dull, diminished sensation to light touch over the posterior thigh and medial calf. The strength on the right quadriceps tibialis anterior and extensor hallucis longus (EHL) were 4/5. The reflexes on the right were +1 in the patella tendon and tendoachilles. The diagnosis was L3-4 and L4-5 stenosis with L4-5 herniated nucleus pulposus to the right side with right lower extremity radiculopathy. The treatment plan included right-sided L3-4 and L4-5 laminotomies and microdiscectomies at L3-4 and L4-5. It was indicated the injured worker had a total of 6 epidural steroid injections which were not helpful. The additional treatment plan included an inpatient hospital stay of 1 to 2 days, a lumbar orthotic brace for 4 to 6 weeks, pre-surgical internal medicine evaluation and clearance, an assistant surgeon, postoperative physical therapy, a front wheeled walker for postoperative care, a home health evaluation and transportation to and from the facility as well as a prescription for Medrox patches apply one patch to affected area 1 to 2 times a day 4 hours on 2 hours off and flurbiprofen 20% gel 120 gm apply to affected area 2 to 3 times a day as directed by physician. The subsequent documentation of 11/22/2013 revealed the injured worker had x-rays of the lumbar spine in 3 views which revealed mild facet hypertrophy at L4-5; otherwise the examination was within normal limits. The treatment plan included at this time, the injured worker had failed non-operative treatments and the previously mentioned treatment that was previously requested was re-requested.

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

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

**LUMBAR SPINE SURGERY WITH [REDACTED]: Upheld**

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

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

**Decision rationale:** The MTUS/ACOEM Guidelines indicate that a surgical consultation is 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, activity limitations due to radiating pain for more than one month or extreme progression of lower leg symptoms, clear clinical, imaging, and electrophysiological evidence of a lesion that has been shown to benefit in both the short term and long term from surgical repair and a failure of conservative treatment to resolve disabling radicular symptoms. The clinical documentation submitted for review indicated the injured worker had an MRI (magnetic resonance imaging) and objective physical examination findings; however, there was a lack of documentation of electrophysiological evidence. There was documentation the injured worker failed conservative treatment. A surgical intervention would not be supported. The request as submitted failed to indicate the laterality and the type of surgery being requested. Given the lack of documentation of exceptional factors to warrant non-

adherence to ACOEM guidelines recommendations, the request for lumbar spine surgery with [REDACTED] is not medically necessary.

**RESTART PHYSICAL THERAPY TWO TIMES PER WEEK X 4 WEEKS FOR LUMBAR SPINE AND RIGHT SHOULDER (35-40 SINCE 2012, PER OFFICE STAFF):**  
Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Practice Guidelines, Pain, Suffering, and the Restoration of Functional Chapter, pg. 114, and Non-MTUS: Official Disability Guidelines (ODG), Low Back and Shoulder Chapters, Physical therapy guidelines.

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

**Decision rationale:** As the requested surgical intervention is not supported by the documentation, the requested ancillary service is also not supported.

**TOPICAL TRANSDERMAL CREAMS, APPLY AS NEEDED:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment Page(s): 47, Chronic Pain Treatment Guidelines Page(s): 111.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Flurbiprofen; Topical analgesics Page(s): 72, 111.

**Decision rationale:** The California MTUS indicates topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. They are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Topical non-steroidal anti-inflammatory drugs (NSAIDs) have been shown in meta-analysis to be superior to placebo during the first two weeks of treatment for osteoarthritis, but either not afterward, or with a diminishing effect over another 2-week period. Flurbiprofen is classified as a non-steroidal anti-inflammatory agent. This agent is not currently Food and Drug Administration (FDA) approved for a topical application. The FDA approved routes of administration for Flurbiprofen include oral tablets and ophthalmologic solution. A search of the National Library of Medicine - National Institute of Health (NLM-NIH) database demonstrated no high quality human studies evaluating the safety and efficacy of this medication through dermal patches or topical administration. The clinical documentation submitted for review indicated the request was for Flurbiprofen. The use of this medication would not be supported per guideline recommendations. The request as submitted failed to indicate the name of the requested transdermal, and the frequency, quantity, and strength for the requested medication. The duration of use could not be established through supplied documentation. Given the above, the request for topical transdermal creams, apply as needed, is not medically necessary.

**LIDODERM PATCHES 1 BOX, APPLY AS NEEDED FOR PAIN:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 56-57. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES, LIDODERM

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines LIDODERM Page(s): 56, 57.

**Decision rationale:** The California MTUS guidelines indicate that topical lidocaine (Lidoderm) may be recommended for localized peripheral pain after there has been evidence of a trial of first-line therapy (tri-cyclic or norepinephrine reuptake inhibitor (SNRI) anti-depressants or an anti-epileptic drug (AED) such as gabapentin or Lyrica). No other commercially approved topical formulations of lidocaine (whether creams, lotions or gels) are indicated for neuropathic pain. The clinical documentation submitted for review failed to indicate the injured worker had a trial and failure of tricyclic or SNRI antidepressants or an AED. The duration of use could not be established through supplied documentation. The request as submitted failed to indicate the strength for the requested medication. Given the above, the request for Lidoderm patches, 1 box apply as needed for pain, is not medically necessary.