

<b>Case Number:</b>	CM14-0020915		
<b>Date Assigned:</b>	04/30/2014	<b>Date of Injury:</b>	05/06/2010
<b>Decision Date:</b>	07/08/2014	<b>UR Denial Date:</b>	02/10/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/19/2014

### 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, 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 claimant is a 52-year-old who injured his hand and knee on May 6, 2010 while cleaning a bucket. The claimant also had underlying complaints of low back pain. The report of a May 1, 2013 lumbar MRI identified degenerative findings at the L2-3 level with foraminal narrowing and an L4-5 paracentral disc protrusion resulting in right neural foraminal narrowing. The records documented that conservative care has included physical therapy, lumbar epidural steroid injections, chiropractic measures and acupuncture. The report of an August 26, 2013 follow up noted ongoing low back and radiating leg pain with physical examination showing 4/5 motor strength with plantar and dorsiflexion of the ankle and sensory change to the dorsal aspect of the right foot. There was a positive right sided straight leg raise. Reviewed at that time was the claimant's prior MRI scan. The recommendation was made for a right L4-5 microdiscectomy.

### IMR ISSUES, DECISIONS AND RATIONALES

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

#### **LUMBAR SPINE SURGERY (RIGHT L4-5 MICRODISCECTOMY AND FORAMINOTOMY): 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): 306.

**Decision rationale:** The records provided for review included the report of an MRI scan that showed a disc protrusion at L4-L5, but no indication of acute neural compressive pathology. ACOEM Guidelines indicate the need for clinical correlation between examination findings demonstrating radicular process and neural compressive findings on imaging. There is an absence of clinical correlation of neurocompressive findings at L4-L5 on imaging and the lack of electrodiagnostic studies to confirm or refute the presence of a radicular process. The request for lumbar spine surgery (right L4-L5 microdiscectomy and foraminotomy) is not medically necessary or appropriate.

**INTERFERENTIAL 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 (ICS) Page(s): 118, 120.

**Decision rationale:** The Chronic Pain Medical Treatment Guidelines would not support the role of an interferential device. The Chronic Pain Guidelines state that Interferential stimulation is not recommended as an isolated intervention nor is it recommended for the acute postoperative setting. The request for an interferential unit is not medically necessary or appropriate.

**FCMC/KETOPROFEN CREAM:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111-113.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines TOPICAL ANALGESICS Page(s): 111-113.

**Decision rationale:** The Chronic Pain Medical Treatment Guidelines would not support the topical compound containing FCMC as well as ketoprofene. The Chronic Pain Guidelines state that Ketoprofene is non FDA approved in the topical setting due to high incidence of photo contact dermatitis. The request for FCMC/Ketoprofen cream is not medically necessary or appropriate.