

<b>Case Number:</b>	CM13-0011604		
<b>Date Assigned:</b>	03/03/2014	<b>Date of Injury:</b>	07/24/2000
<b>Decision Date:</b>	05/07/2014	<b>UR Denial Date:</b>	07/30/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/15/2013

### 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 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 59-year-old who was injured in a work related accident on July 24, 2000, sustaining an injury to the low back. A recent assessment for review includes a September 9, 2013 clinical followup indicating ongoing complaints of low back pain and leg complaints. The physical examination findings at that date showed "no current neurologic signs" with physical examination to the lumbar spine and lower extremities otherwise was negative. The records indicate a prior operative report in this case from November 20, 2013 indicating the claimant underwent an L3-4 anterior lumbar interbody fusion with decompression with use of hardware and bone grafting. The previous review of imaging including April 9, 2013 plain film radiographs demonstrated solid arthrodesis previously performed at the L4-5 and L5-S1 level. There was noted to be segmental instability at the L3-4 level on flexion and extension films. The previous MRI March 14, 2013 demonstrated severe stenosis at the L3-4 level with marked facet hypertrophy and disc protrusion.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**LUMBAR SURGERY L3-4 FUSION:** Overturned

**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:** According to the Low Back Complaints Chapter of the ACOEM Practice Guidelines, "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." Based on the ACOEM Guidelines the retrospective lumbar fusion procedure L3-4 level would have been supported. The preoperative imaging demonstrated significant segmental instability at the L3-4 level with documented severe stenosis disc protrusion concordant physical examination findings. The request for lumbar surgery L3-L4 fusion is medically necessary and appropriate.

**PROTONIX 40MG DAILY:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 68. Decision based on Non-MTUS Citation Non-MTUS Official Disability Guidelines, Pain Chapter

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS (non-steroidal anti-inflammatory drugs), GI (gastrointestinal) Symptoms & Cardiovascular R.

**Decision rationale:** The Chronic Pain Medical Treatment Guidelines would not support the current use of Protonix at the present. This individual has no indication of significant gastrointestinal risk factor per guidelines that would be indicative of need for protective Proton pump inhibitor. The continued role of this agent at this stage in clinical course of care is not supported. The request for Protonix 40 mg daily is not medically necessary or appropriate.

**CALCIUM AND VITAMIN D 500MG Q AM:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Non-MTUS Official Disability Guidelines

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG) OFFICIAL DISABILITY GUIDELINES TREATMENT IN WORKER'S COMP, 18TH EDITION, 2013 UPDATES: PAIN PROCEDURE -

**Decision rationale:** The CA MTUS Guidelines are silent, when looking at the Official Disability Guidelines the role of calcium and vitamin D supplementation would not be indicated. The guidelines give this consideration the chronic pain setting there is no current indication of vitamin D deficiency or current underlying condition for which the use of these agents would be indicated. The request for calcium and vitamin D 500 mg every morning is not medically necessary or appropriate.

**CELEBREX 100MG TID QID:** Overturned

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 22. Decision based on Non-MTUS Citation Non-MTUS Official Disability Guidelines, Pain Chapter

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS (non-steroidal anti-inflammatory drugs) Section.

**Decision rationale:** The Chronic Pain Medical Treatment Guidelines would support the continued use of Celebrex. The claimant is in the early postoperative stages following a secondary fusion procedure. The guidelines indicate the role of anti-inflammatories as traditional first line treatment to reduce pain and increase activity and resume functional activities. The request for Celebrex 100 mg, three to four times daily, is medically necessary and appropriate.

**LIDODERM 5% PATCH, 1 DAILY:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 56-57. Decision based on Non-MTUS Citation Non-MTUS Official Disability Guidelines, Pain Chapter.

**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 indicate the continued need for topical Lidoderm. The Lidoderm is only indicated as a second line agent for treatment of neuropathic pain after first line treatment such as tricyclic antidepressants and agents such as Gabapentin or Lyrica have failed. The records do not indicate evidence of first line treatment. The role of this topical agent at this stage in the clinical course is not supported. The request for Lidoderm 5% patch, once daily, is not medically necessary or appropriate.

**VOLTAREN GEL 1MG QID DAILY:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics 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 do not support the current use of Voltaren gel. The guidelines indicate Voltaren gel is indicated for relief of osteoarthritic pain to the joints that led themselves to topical treatment. This would not include the lumbar spine that is being treated in this case. Given the recent surgical process and concordant use of first line oral non steroidal agents the continued role of this topical application would not be supported. The request for Voltaren Gel 1 mg, four times daily, is not medically necessary or appropriate.

**FLUOCINONIDE 0.05% CREAM: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Non-MTUS Official Disability Guidelines

**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 use of Fluocinonide. The Chronic Pain Medical Treatment Guidelines at present only recommend the role of Diclofenac from an anti-inflammatory point of view in the topical setting. The role of this topical anti-inflammatory given the claimant's current clinical picture is not supported. The request for Fluocinonide 0.05% cream is not medically necessary or appropriate.

**GABA 10# IN LIPOPEN: Upheld**

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

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

**Decision rationale:** The continued role of topical agent that includes Gabapentin would not be indicated. The Chronic Pain Medical Treatment Guidelines state that topical agents are largely experimental with limited long term trials demonstrating functional efficacy of benefit the specific role of Gabapentin. According to the Chronic Pain Medical Treatment Guidelines, it is not recommended without peer review literature to support its use the role of this topical formula is not indicated. The request for Gaba 10% in Lipopen is not medically necessary or appropriate.

**VITAMIN D 10,000 U DAILY: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Non-MTUS Official Disability Guidelines

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Non-MTUS Official Disability Guidelines (ODG), 18th Edition, 2013 Updates: pain procedure

**Decision rationale:** The CA MTUS Guidelines are silent. The Official Disability Guidelines has indicated Vitamin D is not indicated based on the specific request in question number two, the role of vitamin D is not shown to be medically necessary given the claimant's current clinical presentation underlying working diagnosis and current clinical picture. The request for vitamin D,10,000 U daily, is not medically necessary or appropriate.

**MELATONIN 2MG QHS: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), 18th Edition, 2013 Updates: pain procedure.

**Decision rationale:** The CA MTUS Guidelines are silent. When looking at the Official Disability Guidelines criteria, the role of Melatonin as a sleep aide is not indicated. The claimant's clinical picture is not consistent with a diagnosis of insomnia or indication of treatment for sleep related condition. The specific role of this agent is not supported. The request for Melatonin 2 mg every night is not medically necessary or appropriate.