

<b>Case Number:</b>	CM13-0032458		
<b>Date Assigned:</b>	12/11/2013	<b>Date of Injury:</b>	07/06/2010
<b>Decision Date:</b>	01/30/2014	<b>UR Denial Date:</b>	10/03/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/17/2013

### 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 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 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 57-year-old female who reported an injury on July 06, 2010. The patient is currently diagnosed with lumbar discogenic disease, lumbar radiculopathy, and intractable pain. The patient was seen by [REDACTED] on September 03, 2013. The patient complained of persistent lower back pain. Physical examination revealed painful range of motion, spasm; limited range of motion, positive straight leg raising and LasA`gue's testing bilaterally, weakness, and decreased sensation bilaterally at L4-5 and L5-S1. Treatment recommendations included continuation of current medications and authorization for an L3 to L5 fusion.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**one (1) L3-L5 fusion, PFS (posterior spinal fusion) and PLIF (posterior lumbar interbody fusion), between September 3, 2013 and November 29, 2013: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305, Chronic Pain Treatment Guidelines Page(s): 307.

**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 Chapter, Fusion (spinal).

**Decision rationale:** The California MTUS/ACOEM Practice Guidelines state surgical consultation is indicated for patients who have severe and disabling lower extremity symptoms, activity limitations due to radiating leg pain for more than one (1) month, extreme progression of lower extremity symptoms, clear clinical, imaging, and electrophysiological evidence of a lesion that has been shown to benefit from surgical repair, and failure of conservative treatment to resolve disabling radicular symptoms. Patients with increased spinal instability after surgical decompression at the level of degenerative spondylolisthesis may be candidates for a fusion. As per the clinical notes submitted, the patient's latest MRI of the lumbar spine is documented on January 15, 2013. There was grade 1 anterolisthesis with severe canal stenosis and mild bilateral neural foraminal narrowing at L4-5. L1 through L4 were unremarkable. The patient does not demonstrate evidence of a lesion or segmental instability. Therefore, the current procedure cannot be determined as medically appropriate. As such, the request for one (1) L3-L5 fusion, PFS (posterior spinal fusion) and PLIF (posterior lumbar interbody fusion), between September 3, 2013 and November 29, 2013 is non-certified.

**(1) prescription of Restoril 30mg, #60,:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Page(s): 24, Acupuncture Treatment Guidelines, Chronic Pain Treatment Guidelines Benzodiazepines Section Page(s): 24. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chronic Pain Chapter, Insomnia Treatment.

**Decision rationale:** The Official Disability Guidelines state insomnia treatment is recommended based on etiology. Empirically supported treatment includes stimulus control, progressive muscle relaxation, and paradoxical intention. The California MTUS Guidelines state benzodiazepines are not recommended for long-term use because long-term efficacy is unproven and there is a risk of dependence. Most Guidelines limit the use to 4 weeks. As per the clinical notes submitted, the patient has continuously utilized this medication. Despite the ongoing use, satisfactory response to treatment has not been indicated. As Guidelines do not recommend the chronic use of this medication, the current request cannot be determined as medically appropriate. As such, the request for one (1) prescription of Restoril 30mg, #60 is non-certified.

**one (1) prescription of Flexeril 10mg, #90:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants (for pain) Section Page(s): 63-66.

**Decision rationale:** The California MTUS Guidelines state muscle relaxants are recommended as non-sedating second line options for short-term treatment of acute exacerbations in patients

with chronic low back pain. However, they show no benefit beyond NSAIDs in overall improvement and pain. Cyclobenzaprine is recommended for a short-course in therapy and should not be used for longer than 2 to 3 weeks. As per the clinical notes submitted, the patient has continuously utilized this medication. Despite the ongoing use, the patient continues to present with palpable muscle spasm and ongoing pain complaints. Satisfactory response to treatment has not been indicated. As Guidelines do not recommend the chronic use of this medication, the current request cannot be determined as medically appropriate. As such, the request for one (1) prescription of Flexeril 10mg, #90, is non-certified.