

<b>Case Number:</b>	CM15-0183377		
<b>Date Assigned:</b>	09/23/2015	<b>Date of Injury:</b>	11/12/2008
<b>Decision Date:</b>	09/26/2015	<b>UR Denial Date:</b>	09/02/2015
<b>Priority:</b>	Expedited	<b>Application Received:</b>	09/17/2015

### 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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:  
 State(s) of Licensure: California  
 Certification(s)/Specialty: Orthopedic Surgery

### CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

36 year old male with reported industrial injury of 11/12/08. MRI lumbar spine November 6, 2009 demonstrates midline annular tear L4-L5 with 4 mm central disc protrusion/herniation impinging on the L5 nerve roots. Broad based central protrusion is noted at the L5/S1 level. MRI lumbar spine 6/25/15 demonstrates no prior change from the previous exam with facet arthropathy L4-5 and L5-S1. Exam note April 28, 2015 demonstrates low back pain and weakness in the lower extremities. Weakness is noted in dorsiflexion with grossly positive straight leg raise testing. Exam note 8/3/15 demonstrates low back pain with frequent falls and weak left foot. Request is made for disc replacement L4-5, and posterior spinal fusion L5/S1.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Disc replacement, L4-L5 artificial disc replacement/total disc arthroplasty:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 858-859. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back, Dis prosthesis.

**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, Disc prosthesis.

**Decision rationale:** CA MTUS/ACOEM is silent on the issue of disc arthroplasty. According to the ODG, Low Back, Disc prosthesis, it is not recommended. It states, "While artificial disc replacement (ADR) as a strategy for treating degenerative disc disease has gained substantial attention, it is not possible to draw any positive conclusions concerning its effect on improving patient outcomes. The studies quoted below have failed to demonstrate superiority of disc replacement over lumbar fusion, which is also not a recommended treatment in ODG for degenerative disc disease." In this case there is no evidence of any surgically treatable lesion or instability in the lumbar spine from the MRI from 6/25/15. Therefore the determination is not medically necessary.

**Posterior lumbar interbody fusion L5-S1:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 858-859. Decision based on Non-MTUS Citation ACOEM 2nd edition, Chapter 12, Low Back Disorders, 2008 Official Disability Guidelines.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 307. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low back, Fusion.

**Decision rationale:** The ACOEM Guidelines Chapter 12 Low Back Complaints page 307 state that lumbar fusion, "Except for cases of trauma-related spinal fracture or dislocation, fusion of the spine is not usually considered during the first three months of symptoms. Patients with increased spinal instability (not work-related) after surgical decompression at the level of degenerative spondylolisthesis may be candidates for fusion." According to the ODG, Low back, Fusion (spinal) should be considered for 6 months of symptom. Indications for fusion include neural arch defect, segmental instability with movement of more than 4.5 mm, revision surgery where functional gains are anticipated, infection, tumor, deformity and after a third disc herniation. In addition, ODG states, there is a lack of support for fusion for mechanical low back pain for subjects with failure to participate effectively in active rehab pre-op, total disability over 6 months, active psych diagnosis, and narcotic dependence. In this particular patient there is lack of medical necessity for lumbar fusion as there is no evidence of segmental instability greater than 4.5 mm, severe stenosis or psychiatric clearance from the exam note of 8/3/15 to warrant fusion. Therefore the determination is non-certification for lumbar fusion.

**Associated surgical service: Inpatient stay (days) Quantity: 3:** Upheld

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

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**Pre-op H & P:** Upheld

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

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**Associated surgical service: Vascular assistant surgeon:** Upheld

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

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**Associated surgical service: Chem 14:** Upheld

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

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**Associated surgical service: CBC:** Upheld

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

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**Associated surgical service: UA:** Upheld

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

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**Bupropion HCL ER (SR) 100mg Quantity: 360: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Wellbutrin; antidepressants for chronic pain Page(s): 14-16, 27. Char Format.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Bupropion Page(s): 16.

**Decision rationale:** CA MTUS/Chronic Pain Medicat Treatment Guidelines state that Bupropion (Wellbutrin) page 16 is a second generation non-tricyclic antidepressant shown to be effective in relieving neuropathic pain but not for non neuropathic low back pain. As the exam note of 8/3/15 demonstrates no evidence of neuropathic pain, the determination is not medically necessary.

**Flexeril (Cyclobenzaprine HCL) 10mg Quantity: 60: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 41-42, 64.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Cyclobenzaprine Page(s): 41-42.

**Decision rationale:** According to the CA MTUS, Chronic Pain Medical Treatment Guidelines, Cyclobenzaprine, pages 41-42 "Recommended as an option, using a short course of therapy. Cyclobenzaprine (Flexeril) is more effective than placebo in the management of back pain; the effect is modest and comes at the price of greater adverse effects. The effect is greatest in the first 4 days of treatment, suggesting that shorter courses may be better. (Browning, 2001) Treatment should be brief. There is also a post-op use. The addition of cyclobenzaprine to other agents is not recommended." In this particular case the patient has no evidence in the records of 8/3/15 of functional improvement, a quantitative assessment on how this medication helps, percentage of relief lasts, increase in function, or increase in activity. Therefore chronic usage is not supported by the guidelines. Therefore is not medically necessary and non-certified.

**Diclofenac Sodium ER 100mg Quantity: 120: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, chronic pain Page(s): 63, 67. Decision based on Non-MTUS Citation Official Disability Guidelines, 18th edition, 2013, Pain Chapter.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): 67.

**Decision rationale:** CA MTUS/Chronic Pain Treatment Guidelines, NSAIDs, page 67 states, regarding NSAIDs to recommend the lowest dose for the shortest period in patients with moderate to severe pain. According to ODG, Pain section, diclofenac is not recommended as first-line treatment due to increased risk profile. References state that Diclofenac is associated with a significantly increased risk of cardiovascular complications and should be removed from essential-medicines lists, according to a new review. The increased risk with diclofenac was similar to Vioxx, a drug withdrawn from worldwide markets because of cardiovascular toxicity. Rofecoxib, etoricox. Ib, and diclofenac were the three agents that were consistently associated with a significantly increased risk when compared with nonuse. With diclofenac even in small doses it increases the risk of cardiovascular events. They recommended naproxen as the NSAID of choice. In this case, the exam note from 8/3/15 do not establish failure of standard anti-inflammatory medications. Given the increased risks associated with the use of Diclofenac, this medication is not medically necessary.

**Trazodone HCL 50mg Quantity: 90:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressants for chronic pain Page(s): 13-15.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressants Page(s): 13-15.

**Decision rationale:** Per the CA MTUS Chronic Pain Treatment Guidelines Antidepressants for chronic pain Page(s): 13-15, Recommended as a first line option for neuropathic pain, and as a possibility for non-neuropathic pain. Tricyclics are generally considered a first-line agent unless they are ineffective, poorly tolerated, or contraindicated. Analgesia generally occurs within a few days to a week, whereas antidepressant effect takes longer to occur. Assessment of treatment efficacy should include not only pain outcomes, but also an evaluation of function, changes in use of other analgesic medication, sleep quality and duration, and psychological assessment. Side effects including excessive sedation (especially that which would affect work performance) should be assessed. It is recommended that these outcome measurements should be initiated at one week of treatment with a recommended trial of at least 4 weeks. As noted, tricyclic antidepressants, like Trazodone, may play a role in treating neuropathic pain. In this case, the exam note of 8/3/15 does not demonstrate evidence of neuropathic pain. There is no clear-cut evidence to recommend Trazodone first line to treat primary insomnia or neuropathic pain in this case. Therefore determination is not medically necessary.

**Zomig 5mg Nasal solution Quantity: 4:** Upheld

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Head, Zomig.

**Decision rationale:** CA MTUS/ACOEM is silent on the issue of Zomig. ODG, Head section, state Triptans are recommended for migraine sufferers. Zomig (Zolmitriptan) 5mg/spray #12; 1 spray as directed, is a triptan which is recommended for migraine sufferers. A record of pain and function with the medication should be recorded. There is insufficient evidence of migraine from the exam note of 8/3/15 of improvement on Zomig by a VAS score or other measure to warrant the requested medication. Therefore determination is not medically necessary.