

<b>Case Number:</b>	CM14-0129418		
<b>Date Assigned:</b>	08/20/2014	<b>Date of Injury:</b>	04/12/2008
<b>Decision Date:</b>	09/30/2014	<b>UR Denial Date:</b>	08/08/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/14/2014

### 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 Neurological 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 records, presented for review, indicate that this 46-year-old individual was reportedly injured on April 12, 2008. The mechanism of injury was not listed in these records reviewed. The most recent progress note, dated March 5, 2014, indicated that there were ongoing complaints of low back pain. No specific physical examination was completed or reported at the time of this evaluation. Diagnostic imaging studies objectified ordinary disease of life degenerative disc disease, disc desiccation, disk herniation, disk space narrowing and a possible spina bifida occulta. Degenerative osteophytes were also noted. Previous treatment included multiple medications, physical therapy, chiropractic intervention, lumbar surgery and pain management interventions. Also noted was a comorbidity of cardiac arrhythmia that was noted to be refractory to medical therapy. An ablation procedure to control the arrhythmia was completed. A request had been made for preoperative psychological evaluation, lumbar artificial disc replacement, back buddy muscle massager and multiple medications and was not certified in the pre-authorization process on August 8, 2014.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Pre-Operative Psychology Evaluation:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 306.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) Low Back Disorders: surgical considerations; disc replacement( electronically cited).

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

**Lumbar artificial disc replacement:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 306. Decision based on Non-MTUS Citation Official Disability Guidelines, Degenerative Disc Disease.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) Low Back Disorders: Clinical Measures; Surgical Considerations-Disc Replacement (Electronically Cited).

**Decision rationale:** As outlined in the ACOEM practice guidelines, artificial disc replacement is not recommended as a treatment for chronic low back pain clinical situation. When noting the injury sustained, and the findings identified on imaging studies, there is insufficient clinical evidence presented to establish the medical necessity for this procedure. Therefore this request is not medically necessary.

**Back Buddy Muscle Massager:** Upheld

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

**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 - Lumbar and Thoracic; Massage.

**Decision rationale:** ODG does not recommend mechanical massage devices for low back pain. This is a commercially prepared device that does not have an associated evidence-based medicine literature to support use of such a device. As such, there is no clear clinical indication to establish the medical necessity.

**Soma 350mg (unspecified quantity):** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines 7/18/09 Page(s): 65.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 29.

**Decision rationale:** The MTUS specifically recommends against the use of Soma and indicates that it is not recommended for long-term use. Based on the clinical documentation provided, the clinician does not provide rationale for deviation from the guidelines. As such, with the very specific recommendation of the MTUS against the use of this medication, this medication is not medically necessary.

**Levothyroxine Sodium 50mcg:** Upheld

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: -Vaidya B, Pearce SH. Management of hypothyroidism in adults. British Medical Journal (Clinical research ed.). 2008;337:a801.

**Decision rationale:** This medication is useful in the treatment of hypothyroidism. There is no narrative presented in the progress notes indicating that there is thyroid disease. As such, there is insufficient clinical information presented to support the medical necessity of this request. Therefore this request is not medically necessary.

**Androderm 4mg/24hr patch quantity 90.00:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, 12th Edition, 2014, Pain.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence:-Reed WL, Clark ME, Parker PG, Raouf SA, Arguedas N, Monk DS, Snajdr E, Nolan V, Ketterson ED (May 2006). "Physiological effects on demography: a long-term experimental study of testosterone's effects on fitness". Am. Nat. 167 (5): 667-83.

**Decision rationale:** This is a topical testosterone product. The progress notes presented for review do not indicate that there is any clinical indication for testosterone replacement therapy. The progress notes do not address this medication in any manner similar. Therefore, this request is not medically necessary.

**Cialis 20mg quantity 10.00:** Upheld

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical

Evidence:-Bischoff, E (June 2004). "Potency, selectivity, and consequences of nonselectivity of PDE inhibition". International Journal of Impotence Research 16: S11-4.

**Decision rationale:** This medication is a PDE5 inhibitor that is sometimes used in the treatment of erectile dysfunction. The progress notes presented for review do not mention any evidence of such a condition. Therefore, there is insufficient data presented to support the medical necessity of this request. Therefore this request is not medically necessary.

**Lidoderm 5% patch quantity 120.00:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines 7/18/09 Page(s): 26.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 56, 57, 112.

**Decision rationale:** MTUS guidelines support the use of topical lidocaine for individuals with neuropathic pain that have failed treatment with first-line therapy including antidepressants or anti-epileptic medications. Based on the clinical documentation provided, the claimant continues to have degenerative changes and low back pain. There is no current electrodiagnostic evidence to support a neuropathic lesion. As such, the request is considered not medically necessary.