

<b>Case Number:</b>	CM14-0074285		
<b>Date Assigned:</b>	07/16/2014	<b>Date of Injury:</b>	06/05/2004
<b>Decision Date:</b>	06/29/2015	<b>UR Denial Date:</b>	05/17/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/21/2014

### 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. 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: Illinois, California, Texas  
 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:

The injured worker is a 47-year-old male who sustained an industrial injury on 6/5/04. Injury occurred while he was washing a machine, slipped and fell approximately 5-6 feet to cement. Past surgical history was positive for right L4/5 percutaneous discectomy on 8/11/11. The 4/18/12 lumbar spine MRI impression documented a new far right lateral disc protrusion at L4/5 with effacement of the right lateral recess and increased stenosis of the right L4/5 foramen which was moderately narrowed and could affect the L4 nerve root. There was stable mild central canal stenosis at L4/5. At L5/S1, there was a small central disc protrusion with minimal mass effect on the thecal sac. Records documented that cyclobenzaprine had been prescribed as a topical agent since at least 6/2/12, and as an oral medication since at least 12/17/12. Doral has been prescribed since at least 12/4/13. The 4/15/14 treating physician handwritten report indicated that the injured worker was status post lumbar spine discectomy and was having residual lumbar pain especially over the bilateral sacroiliac joints. Pain radiated down the right leg with numbness and tingling. Lumbar spine exam documented paraspinal tenderness, decreased range of motion secondary to pain, right sacroiliac joint tenderness, positive FABER, positive Patrick's, and decreased right S1 sensation. The diagnosis included lumbar disc bulge. The treatment plan recommended continued medications and compound creams. Authorization was requested for L4/5 and L5/S1 posterior lumbar interbody fusion with posterior spinal fusion and sacroiliac joint fixation and arthrodesis. Additional requests included Doral 15 mg #60; Fexmid 7.5 mg #120 and cyclobenzaprine 60 gm tube. The 5/17/14 utilization review non-certified the L4/5 fusion with extension to L5/S1 and sacroiliac fixation and arthrodesis as there was no

documentation of spinal instability, failed conservative treatment, or provocative testing to validate pain generators, and lack of support by the second opinion orthopedic consultation. The request for Doral 15 mg #60 was modified to Doral 15 mg #55 as guidelines did not support chronic use and to allow for weaning. The request for Fexmid 7.5 mg #120 was non-certified as chronic use was not supported and there was a lack of documented efficacy with prior use. The request for cyclobenzaprine 60 gm tube was non-certified as there was no guideline support for the topical use of muscle relaxants.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

#### **L4-L5 fusion with extension to L5-S1 and sacroiliac fixation and arthrodesis: 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 Indications for Surgery-Discectomy.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-307. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Lumbar & Thoracic: Fusion (spinal); Hip & Pelvis: Sacroiliac joint fusion.

**Decision rationale:** L4-L5 fusion with extension to L5-S1 and sacroiliac fixation and arthrodesis. The California MTUS guidelines indicate that lumbar spinal fusion may be considered for patients with increased spinal instability after surgical decompression at the level of degenerative spondylolisthesis. Guidelines state there was no good evidence that spinal fusion alone was effective for treating any type of acute low back problem, in the absence of spinal fracture, dislocation, or spondylolisthesis if there was instability and motion in the segment operated on. The Official Disability Guidelines (ODG) state that spinal fusion is not recommended for patients who have less than six months of failed recommended conservative care unless there is objectively demonstrated severe structural instability and/or acute or progressive neurologic dysfunction. Guidelines state that spinal fusion is recommended as an option for spinal fracture, dislocation, spondylolisthesis or frank neurogenic compromise, subject to the selection criteria. Fusion is recommended for objectively demonstrable segmental instability, such as excessive motion with degenerative spondylolisthesis. Pre-operative clinical surgical indications require completion of all physical therapy and manual therapy interventions, x-rays demonstrating spinal instability, spine pathology limited to 2 levels, and psychosocial screening with confounding issues addressed. The Official Disability Guidelines do not recommend sacroiliac joint fusion except as a last resort for chronic or severe sacroiliac joint pain. Guidelines indicate that the diagnosis of sacroiliac joint pain is controversial and difficult to make accurately, and the evidence base for fusion to treat this vague diagnosis is weak and conflicted. Guideline criteria have not been met. This injured worker presents with lower back and bilateral sacroiliac joint pain radiating down the right leg with numbness and tingling. Clinical exam findings were consistent with imaging evidence of plausible nerve root compression at L5/S1. However, there was no radiographic evidence of spinal segmental instability or sacroiliac joint arthropathy in the submitted records. There was no discussion of the need for wide decompression resulting in temporary intraoperative instability. Detailed evidence of a recent, reasonable and/or comprehensive non-operative treatment protocol trial and failure has not been submitted. There was no evidence of a positive sacroiliac joint diagnostic block. There was no evidence of psychosocial screening. Therefore, this request is not medically necessary.

**Doral 15 mg #60:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines Page(s): 24.

**Decision rationale:** The California MTUS do not recommend the use of benzodiazepines, like Doral (Quazepam), for long-term use. Most guidelines limit use to 4 weeks. Chronic benzodiazepines are the treatment of choice in very few conditions. The continued use of this medication is not supported by guidelines. Records indicate that this medication has been prescribed since at least 12/4/13. There is no documentation of any specific benefit or indication for continued use. The 5/17/14 utilization review modified this request for Doral 15 mg #60 to Doral 15 mg #55 to allow for weaning. There is no compelling reason to support the medical necessity of additional certification of this medication in the absence of guidelines support. Therefore, this request is not medically necessary.

**Fexmid 7.5 mg #120:** Upheld

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

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

**Decision rationale:** The California MTUS guidelines recommend the use of cyclobenzaprine (Fexmid) as an option, using a short course of therapy, in the management of back pain. Treatment should be brief. This medication is not recommended to be used for longer than 2 to 3 weeks. Guideline criteria have not been met for continued use. Records indicate that this medication has been prescribed since at least 12/17/12. There is no documentation of specific functional benefit associated with the injured worker's use of this medication. Given the absence of guideline support beyond 2 to 3 weeks, discontinuation is indicated. Therefore, this request is not medically necessary.

**Cyclobenzaprine 60 gm tube:** Upheld

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

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

**Decision rationale:** The California MTUS guidelines state that topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. There is little to no research to support the use of many of these agents. Guidelines state there is no evidence for use of a muscle relaxant, such as cyclobenzaprine, as a topical product. Given the absence of guideline support, this request is not medically necessary.