MAXIMUS Federal Services

Case Number:	CM13-0001000		
Date Assigned:	11/08/2013	Date of Injury:	05/16/2013
Decision Date:	08/11/2014	UR Denial Date:	07/01/2013
Priority:	Standard	Application Received:	07/08/2013

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 Physical Medicine and Rehabilitation, 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 injured worker is a 47-year-old male who reported an injury on 05/16/2005. The mechanism of injury reportedly occurred while driving a forklift in reverse. The diagnoses included lumbar radiculopathy, lumbar degenerative disc disease, and low back pain. Prior therapies included 2 epidural steroid injections, an H-wave unit, and physical therapy. Per the 05/02/2013 progress note, the injured worker reported low back pain rated 8/10 without medications and 4/10 with medications. It was noted the injured worker received 50% pain relief for 4 to 5 months from an epidural steroid injection performed 01/03/2012. It was noted tizanidine and Norco helped with pain management. The injured worker reported H-wave helped alleviate his pain and that he had been using it for 3 to 4 years. Physical exam findings included 2+ deep tendon reflexes and 5/5 strength in the bilateral lower extremities. The injured worker demonstrated positive straight leg raising bilaterally. Decreased sensation was noted in the right lower extremity. The injured worker's medications included Lidoderm patches, tizanidine HCl 4 mg, and Terocin cream. Per the 12/30/2013 progress note, the injured worker continued to report radiating low back pain rated 9/10 without medications and 4/10 with medications. Physical exam findings included 2+ patellar deep tendon reflexes and 1+ Achilles deep tendon reflexes bilaterally. Sensation was noted to be intact but decreased over the right lower extremity in the L4 and L5 dermatomes. The injured worker's medications were unchanged. The Request for Authorization Form for continued use of H-wave and supplies was submitted 06/19/2013. The Request for Authorization for lumbar ESI, tizanidine, Lidoderm patches, and Terocin lotion was submitted 09/19/2013.

IMR ISSUES, DECISIONS AND RATIONALES

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

LIDOCAINE 5% PATCH #60 WITH 5 REFILLS.: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines LIDODERM(LIDOCAINE PATCH).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Lidoderm(lidocaine patch) Page(s): 56-57.

Decision rationale: The request for lidocaine 5% patch quantity 60 with 5 refills is not medically necessary. The California MTUS Guidelines state Lidoderm patches are not a first line treatment and are only FDA approved for postherpetic neuralgia. Further research is needed to recommend this treatment for chronic neuropathic pain disorders other than post-herpetic neuralgia. The medical records provided indicate a prescription for Lidoderm patches since at least 05/02/2013. There is no documentation regarding significant pain relief and objective functional improvements with use. There is no indication the injured worker had a diagnosis of postherpetic neuralgia. The guidelines state Lidoderm patches are only FDA approved for postherpetic neuralgia. Based on this information, the request is not supported. Therefore, the request is not medically necessary.

TIZANIDINE HCL 4MG #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines CHAPTER: TIZANIDINE (ZANAFLEX).

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

Decision rationale: The request for Tizanidine HCl 4 mg quantity 60 is not medically necessary. The California MTUS Guidelines recommend non-sedating muscle relaxants with caution as a second line option for short term treatment of acute exacerbations in patients with chronic low back pain. Efficacy appears to diminish over time, and prolonged use of some medications in this class may lead to dependence. The medical records provided indicate a prescription for Tizanidine since at least 05/02/2013. The guidelines do not support the long term use of muscle relaxants. Based on this information, continued use is not supported. Therefore, the request is not medically necessary.

LIDO-CAPSAICIN-MEN-METHYL SAL TEROCIN #60ML: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines CHAPTER: TOPICAL ANALGESICS.

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

Decision rationale: The request for lido-capsaicin-men-methyl sal Terocin #60 ml is not medically necessary. The California MTUS Guidelines state topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. Any compounded product that contains at least one drug that is not recommended is not recommended. The only commercially approved topical formulation of lidocaine for neuropathic pain is Lidoderm. Capsaicin is recommended only as an option in patients who have not responded or are intolerant to other treatments. Topical NSAIDs are not recommended as there is no evidence to support their use for neuropathic pain. The requested cream contains at least 1 drug that is not recommended; therefore, its use is not supported. Therefore, the request is not medically necessary.

1 LUMBAR EPIDURAL STEROID INJECTION BILATERALLY AT L4-L5: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines CHAPTER: EPIDURAL STEROID INJECTIONS (ESIS).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural steroid injections (ESIs) Page(s): 46.

Decision rationale: The request for 1 lumbar epidural steroid injection bilaterally at L4-5 is not medically necessary. The California MTUS Guidelines state the purpose of epidural steroid injections is to facilitate progress in more active treatment programs, but injections alone offer no significant long term functional benefit. Repeat blocks should be based on continued objective documented pain and functional improvement, including at least 50% pain relief with associated reduction of medication use for 6 to 8 weeks. The guidelines recommend no more than 2 epidural steroid injections. The medical records provided indicate the injured worker received epidural steroid injections in 2009 and 2012. The injured worker reported at least 50% reduction in pain lasting 4 to 5 months from the epidural steroid injection performed in 2012. There is no documentation regarding the previous epidural steroid injections to verify objective functional improvements and reduction in medications. There is no indication of the failure of a recent trial of conservative care. There is no indication the injured worker plans to participate in more active treatment programs in conjunction with the injection. In addition, there is no physical exam finding to support injections at bilateral L4-5. Based on this information, the request is not supported. Therefore, the request is not medically necessary.

ONE CONTINUED USE OF H-WAVE SYSTEM AND SUPPLIES.: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines CHAPTER: H-WAVE STIMULATION (HWT).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrotherapy Page(s): 114-121.

Decision rationale: The request for one continued use of H-wave system and supplies is not medically necessary. The California MTUS Guidelines state H-wave is not recommended as an isolated intervention, but a 1 month home based trial of H-wave stimulation may be considered

as a noninvasive conservative option for diabetic neuropathic pain or chronic soft tissue inflammation if used as an adjunct to a program of evidence-based functional restoration, and only following failure of initially recommended conservative care, including recommended physical therapy and medications, plus transcutaneous electrical nerve stimulation. The medical records provided indicate the injured worker had been using H-wave for 3 to 4 years. He reported it alleviated his pain. There is a no documentation regarding the failure of other conservative measures such as physical therapy, medications, and transcutaneous electric nerve stimulation. There is no indication the injured worker was using H-wave as an adjunct to a program of evidence-based functional restoration. There is no documentation regarding significant pain relief and objective functional improvements with the use of H-wave. In addition, the submitted request does not specify the site of treatment. Therefore, the request is not medically necessary.