

Case Number:	CM13-0007427		
Date Assigned:	12/11/2013	Date of Injury:	06/06/1990
Decision Date:	03/04/2014	UR Denial Date:	07/03/2013
Priority:	Standard	Application Received:	08/06/2013

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 Occupational Medicine, 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 applicant is a represented [REDACTED] employee who has filed a claim for neck, shoulder, and low back pain reportedly associated with an industrial injury of June 6, 1990. Thus far, the applicant has been treated with the following: Analgesic medications; attorney representation; transfer of care to and from various providers in various specialties; muscle relaxants; topical agents; prior lumbar spine surgery; unspecified amounts of physical therapy; and extensive periods of time off of work. In a Utilization Review Report of July 3, 2013, the claims administrator reportedly denied a request for cervical and lumbar MRI imaging, denied a request for back brace, denied a request for a walker, denied a request for Lidoderm patches, and partially certified several medications for weaning purposes. The utilization review decision is quite difficult to follow, it is incidentally noted. The applicant's attorney subsequently appealed. Subsequent progress note of October 21, 2013 is notable for comments that the applicant is now 77 years old. He is having ongoing issues with low back pain radiating to bilateral lower extremities. He is also reporting neck pain radiating to the right wrist and left biceps region. His pain has gotten progressively worse and is constant. He is reportedly "permanently disabled." Pain is preventing him from engaging in activities. His scooter is broken. The applicant is having difficulty with neck and arm pain and is unable to propel a manual wheelchair, it is stated. He is presently on OxyContin, Dilaudid, Soma, and Amitiza as needed for constipation, Lidoderm, quinine, Neurontin, and tizanidine. Diminished bilateral lower extremity strength is noted ranging from 3-4/5 versus 5/5 upper extremity strength. Positive straight leg raising is noted about the lower extremities. MRI imaging of the cervical and lumbar spines is sought. It is stated that the applicant may be a candidate for interventional spine procedures, surgery, and/or spinal cord stimulator. A lumbar support and motorized wheelchair are sought, along with several medication refills.

IMR ISSUES, DECISIONS AND RATIONALES

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

Cervical MAGNETIC RESONANCE IMAGING (MRI): Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM. Decision based on Non-MTUS Citation (ODG) Official Disability Guidelines.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints.

Decision rationale: As noted in the MTUS-adopted ACOEM Guidelines in Chapter 8, Table 8-8, MRI or CT imaging is "recommended" to validate a diagnosis of nerve root compromise, based on clear history and physical findings, in preparation for an invasive procedure. In this case, the applicant does have ongoing complaints of neck pain radiating to the bilateral upper extremities. He is reportedly a candidate for further cervical spine surgery and/or spinal cord stimulator implantation trial. He does have associated hyposensorium noted about the upper extremities. Thus, there is evidence of neurologic compromise present here. The applicant is potentially a candidate for interventional procedure. Criteria for pursuit of cervical MRI imaging have been met. Therefore, the request is certified.

Lumbar MAGNETIC RESONANCE IMAGING (MRI): Overturned

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

Decision rationale: As noted in the MTUS-adopted ACOEM Guidelines in Chapter 12 Table 12-8, MRI imaging is the test of choice for applicants with prior spine surgery. In this case, the applicant has had prior spine surgery. He does have lower extremity motor deficits. He is using a wheelchair. He is apparently a candidate for further surgery versus other interventional spine procedures such as spinal cord stimulator. MRI imaging is therefore indicated to clearly delineate the nature of the applicant's neurologic deficits. Accordingly, the request is certified.

Wheelchair: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Power Mobility Devices (PMD)'s.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Power Mobility Devices (PMD)'s.

Decision rationale: As noted on Page 99 of the MTUS Chronic Pain Medical Treatment Guidelines, power mobility devices such as the wheelchair being proposed here are

recommended if an applicant has upper extremity deficits which prevent or reduce an applicant's ability to propel a manual wheelchair. In this case, the applicant is seemingly having difficulty ambulating. He has weakness about the lower extremities. He has comorbid upper extremity deficits that are apparently preventing usage of manual wheelchair. A motorized wheelchair is therefore indicated in this context. Accordingly, the request is certified.

Lidoderm patch 5%: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Lidocaine.

Decision rationale: As noted on page 112 of the MTUS Chronic Pain Medical Treatment Guidelines, topical Lidoderm patches are indicated in the treatment of neuropathic pain in individuals who have tried and failed first line antidepressants and/or anticonvulsants. In this case, however, the applicant has already used Lidoderm for some time. There is no evidence of program progression and/or functional improvement effected through prior usage of Lidoderm. The fact that the applicant remains off of work, has been deemed permanently disabled, has significant physical impairment, and is highly reliant on various diagnostic tests and medical treatments, taken together, imply a lack of functional improvement as defined in MTUS 9792.20f despite prior usage of Lidoderm. Therefore, the request is not certified.

Quinine #30: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: FDA:
<http://www.fda.gov/downloads/Drugs/GuidanceComplianceRegulatoryInformation/EnforcementActivitiesbyFDA/SelectedEnforcementActionsonUnapprovedDrugs/ucm119653.pdf>

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

Decision rationale: The MTUS does not address the topic. As noted by the Food and Drug Administration (FDA), only one quinine product has been approved by the Food and Drug Administration, the variant of quinine which is being employed as an antimalarial. In this case, however, there is no evidence that the applicant carries a diagnosis of malaria for which usage of quinine will be indicated. Rather, it appears that the attending provider is employing quinine for off label purpose of an antispasmodic. This is not an approved indication, per the FDA. Therefore, the request is not certified.

Soma 350mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Carisprodol (Soma).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Carisoprodol (Soma).

Decision rationale: As noted on page 20 of the MTUS Chronic Pain Medical Treatment Guidelines, carisoprodol or Soma is not recommended for long-term use purposes, particularly when employed in conjunction with other medications such as opioids. In this case, the applicant is already using numerous other analgesic medications. Adding carisoprodol or Soma to the mix is not indicated. Therefore, the request is likewise not certified.