MAXIMUS Federal Services

Case Number:	CM13-0022031		
Date Assigned:	03/19/2014	Date of Injury:	06/16/2003
Decision Date:	04/23/2014	UR Denial Date:	08/12/2013
Priority:	Standard	Application Received:	09/09/2013

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, has a subspecialty in Interventional Spine, 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 patient is a 68 year-old male with date of injury of 06/16/2003. The listed diagnoses per [redacted] dated 07/08/2013 are of the following: 1. Degenerative disk disease of the lumbar spine with primarily left-sided radiculopathy 2. Lumbar stenosis 3. Lumbar facet syndrome 4. Left hip greater trochanteric bursitis. 5. Medication-induced gastritis According to progress report dated 07/08/2013 by [redacted], the patient presents with on-going low back pain. He rates his pain a 5/10 on the pain scale. He does report some increased pain since his last visit but denies any recent trauma. The patient denies any pain or numbness in his legs. His current medications include Norco 5/325 mg, ibuprofen 600 mg, and Terocin cream to help decrease his pain. He denies any side effects to his medications. Objective findings show the patient is alert, oriented in no acute distress. There is tenderness to palpation over the lumbar paraspinals as well as facet joints of the lumbar spine. Range of motion of the lumbar spine is decreased in all planes with increased pain upon extension. Positive facet challenge. Lower extremity sensation is intact bilaterally. Motor exam is 4+/5 for left EHL and inversion. The remainder of the lower extremity motor function is 5/5. The treater is requesting Terocin and an MRI of the lumbar spine.

IMR ISSUES, DECISIONS AND RATIONALES

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

TEROCIN: 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, CHRONIC PAIN SECTION Page(s): s 111-112.

Decision rationale: This patient presents with chronic low back pain. This patient does not present with peripheral joint problems. Lidocaine is not indicated either as the patient is not using this product for neuropathic pain, but for low back pain. Report 7/8/13 also mentions that there are no numbness or pain in the legs. MTUS guidelines do not recommend a compounded product if one of the compounds are not indicated. Neither lidocaine, nor Salicylate topicals are indicated in this patient. Recommendation is for denial.

MRI LUMBER SPINE: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): s 303, 177-178. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG) ODG TWC GUIDELINES, MRI, HTTP://WWW.ODGTWC.COM/ODGTWC/LOW_BACK.HTM#PROTOCOLS

Decision rationale: This patient presents with chronic low back pain. ACOEM Guidelines page 177 to 178 list their criteria for ordering imaging studies which include emergence of a red flag; physiologic evidence of tissue insult or neurologic dysfunction; failure to progress in a strengthening program intended to avoid surgery and clarification of the anatomy prior to an invasive procedure. Review of 16 pages of records do not show evidence of recent or prior MRI. Progress report dated 07/08/2013 by [redacted], documents: He does report some increased pain since his last visit, but denies any recent trauma. He reports increased pain in the morning. The patient denies any pain or numbness in his legs currently. In this case, the patient does not present with a recent trauma or radiating symptoms into legs to suspect nerve root lesion or tissue injury. Given the lack of documented neurologic dysfunction as evidenced by physical examination, recommendation is for denial.