

Case Number:	CM13-0034671		
Date Assigned:	12/11/2013	Date of Injury:	04/08/2004
Decision Date:	02/20/2014	UR Denial Date:	09/27/2013
Priority:	Standard	Application Received:	10/15/2013

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 Family Practice and is licensed to practice in Texas. 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 patient is a 31-year-old female who reported an injury on 04/08/2004. The mechanism of injury was not provided for review. The patient underwent an MRI of the lumbar spine that revealed an intervertebral body fusion, a small posterior disc bulge at the L4-5 level and lower lumbar facet joint arthropathy. The prior treatments included psychiatric support, a back brace, hot and cold therapy, and a TENS unit in combination with multiple medications. The patient also underwent a course of acupuncture that did not provide significant benefit. The patient's most recent clinical examination findings included significantly restricted range of motion secondary to pain, tenderness to palpation throughout the paraspinal musculature, a negative straight leg raise test bilaterally. The patient's diagnoses included chronic low back pain with lumbar fusion at the L5-S1 with hardware removal, and disc bulging at the L4-5. The patient's treatment plan included continuation of medications, participation in a home exercise program, and a functional restoration program.

IMR ISSUES, DECISIONS AND RATIONALES

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

Hot/cold wrap: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) - cryotherapy.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints
Page(s): 303-305.

Decision rationale: The requested hot/cold wrap is not medically necessary or appropriate. The clinical documentation submitted for review does provide evidence that the patient has previously used this treatment modality in an attempt to control the patient's pain. The American College of Occupational and Environmental Medicine do recommend the use of hot/cold therapy in the management of acute and chronic back pain. However, as there is no documentation of increased functional benefit and symptom response of the patient's prior hot/cold therapy, continuation of this treatment modality would not be supported. As such, the request for hot/cold wrap is not medically necessary or appropriate.

Back brace: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) - lumbar supports

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints
Page(s): 307.

Decision rationale: The requested back brace is not medically necessary or appropriate. The American College of Occupational and Environmental Medicine do not recommend bracing as a treatment modality for chronic back pain as there is no scientific evidence to support the efficacy of this treatment. Additionally, the clinical documentation submitted for review does provide evidence that the patient previously received a lumbar support. The clinical documentation submitted for review does not address the efficacy of the prior lumbar support. Therefore, an additional lumbar support would not be indicated. As such, the requested back brace is not medically necessary or appropriate.

Nerve studies (EMG): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines electrodiagnostic studies.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints
Page(s): 303-305.

Decision rationale: The requested nerve studies (EMG) is not medically necessary or appropriate. The clinical documentation submitted for review does provide evidence that the patient has a disc bulge at the L4-5 level. However, there is no imaging evidence to support nerve root involvement. Additionally, American College of Occupational and Environmental Medicine recommend electrodiagnostic studies when there is some indication of radiculopathy or nerve root impingement that is not clearly evident throughout the physical exam. The clinical documentation submitted for review does not provide any evidence of nerve root involvement. The patient had a negative straight leg raising test, normal motor strength of the lower

extremities, and no sensational disturbances. Additionally, it is not clearly identified how an electrodiagnostic study would contribute to the patient's treatment plan. The prescribing physician documented within the most recent chart notes that the patient is not a surgical candidate and would not benefit from additional invasive procedures. As such, the requested nerve studies (EMG) is not medically necessary or appropriate.

Percocet #120: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids On-Going Management Page(s): 78.

Decision rationale: The requested Percocet #120 is not medically necessary or appropriate. California Medical Treatment Utilization Schedule recommends the continued use of opioids be supported by a quantitative assessment of pain relief, management of side effects, monitoring of aberrant behavior, and documentation of specific increased functional activity. The clinical documentation submitted for review does not provide any evidence that the patient is monitored for aberrant behavior, has definitive pain relief related to the medication, or has any functional benefit from continuation of this medication. Therefore, continuation of this medication would not be supported. As such, the requested Percocet #120 is not medically necessary or appropriate.

Norflex #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 63.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants Page(s): 63.

Decision rationale: The requested Norflex #60 is not medically necessary or appropriate. California Medical Treatment Utilization Schedule recommends the short-term use of muscle relaxants for acute exacerbations of chronic pain. However, the clinical documentation submitted for review indicated that the patient did not have an appropriate response to this medication and it was discontinued by the prescribing physician. Therefore, further use would not be indicated. As such, the requested Norflex #60 is not medically necessary or appropriate.

Prilosec 20mg, #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines proton pump inhibitors..

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk Page(s): 68.

Decision rationale: The requested Prilosec 20 mg #120 is not medically necessary or appropriate. California Medical Treatment Utilization Schedule recommends a gastrointestinal protectant for patients at risk for developing gastrointestinal events related to long-term medication usage. The clinical documentation submitted for review does not provide adequate assessment of the patient's gastrointestinal system to provide deficits that would require medication management. Additionally, an assessment of the patient's risk factors for developing gastrointestinal events related to medication usage was not addressed within the documentation. Therefore, continued use of this medication would not be supported. As such, the requested Prilosec 20 mg #120 is not considered medically necessary or appropriate.

Terocin patches #30: 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.

Decision rationale: The requested Terocin patches #30 are not medically necessary or appropriate. California Medical Treatment Utilization Schedule does not support the use of topical analgesics as they are considered largely experimental and are not supported by extensive scientific research. The requested Terocin patch includes elements such as methyl salicylate, capsaicin, menthol, and lidocaine. The California Medical Treatment Utilization Schedule does recommend the use of methyl salicylate and menthol as a topical agent for osteoarthritic pain. However, the use of capsaicin is only recommended for patients who are intolerant or unresponsive to other treatments. The clinical documentation submitted for review does not clearly indicate if the patient has failed to respond to other oral analgesics that would support the need for a topical agent such as capsaicin. California Medical Treatment Utilization Schedule recommends the use of lidocaine in a patch be supported by significant functional benefit and symptom relief. The clinical documentation submitted for review does not provide any evidence of functional benefit or symptom relief as it is related to this medication. Also, the California Medical Treatment Utilization Schedule recommends the introduction of pain medications for the management of chronic pain be introduced 1 at a time. Therefore, a formulation of medication with multiple medications would not be indicated. As such, the requested Terocin patches are not medically necessary or appropriate.

LidoPro cream: 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): 60, 111.

Decision rationale: The requested LidoPro cream is not medically necessary or appropriate. California Medical Treatment Utilization Schedule does not support the use of topical analgesics as they are considered largely experimental and are not supported by extensive scientific research. The requested LidoPro cream includes elements such as methyl salicylate, capsaicin, menthol, and lidocaine. The California Medical Treatment Utilization Schedule does recommend the use of methyl salicylate and menthol as a topical agent for osteoarthritic pain. However, the use of capsaicin is only recommended for patients who are intolerant or unresponsive to other treatments. The clinical documentation submitted for review does not clearly indicate if the patient has failed to respond to other oral analgesics that would support the need for a topical agent such as capsaicin. California Medical Treatment Utilization Schedule does not support the use of lidocaine in a topical cream as it is not FDA approved in this formulation to treat neuropathic pain. Additionally, the clinical documentation submitted for review does not provide any evidence of functional benefit or symptom relief as it is related to this medication. Also, the California Medical Treatment Utilization Schedule recommends the introduction of pain medications for the management of chronic pain be introduced 1 at a time. Therefore, a formulation of medication with multiple medications would not be indicated. As such, the requested LidoPro cream is not medically necessary or appropriate.

Trazodone 50mg, #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation ODG Guidelines- sedating anti-depressants.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter, Insomnia related to chronic pain.

Decision rationale: California Medical Treatment Utilization Schedule (MTUS), 2009, American College of Occupational and Environmental Medicine (ACOEM), Occupational Medical Practice Guidelines, Second Edition (2004), does not address insomnia related to chronic pain. The requested trazodone 50 mg #30 is not medically necessary or appropriate. Official Disability Guidelines recommend the use of sedating antidepressants such as trazodone for patients with insomnia related to chronic pain. The clinical documentation submitted for review does not provide any evidence of poor sleep hygiene that would benefit from pharmacological management. Additionally, there is no documentation that the patient has attempted non-pharmacological management of any sleep deprivation complaints. As such, the requested trazodone 50 mg #30 is not medically necessary or appropriate.

Labs: CBC and UA: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Urine Drug Testing. Page(s): 67-90, 43, 77, 89. Decision based on Non-MTUS Citation Official Disability Guidelines, Chronic Pain Chapter, Urine Drug Testing.

Decision rationale: California MTUS Guidelines recognize the risk for liver and kidney problems due to long-term and high dose use of NSAIDs and acetaminophen. There has been a recommendation to measure liver transaminases within 4 to 8 weeks after starting therapy, but the interval of repeating lab tests after this treatment duration has not been established. Repeat testing is based on patient risk factors and related symptoms suggesting a problem related to kidney or liver function. The patient exhibits no symptoms to suggest abnormality due to medication use; therefore, it would not be necessary to perform laboratory evaluations every 3 months for 1 year. California MTUS Guidelines further state drug testing is recommended as an option, using a urine drug screen to assess for the use or presence of illegal drugs. The Official Disability Guidelines state the frequency of urine drug testing should be based on documented evidence of risk stratification, including the use of a testing instrument. Patients at low risk of addiction or aberrant behaviors should be tested within 6 months of initiation of therapy and on a yearly basis thereafter. As per the clinical notes submitted, the patient's injury was over 9 years ago to date, and there is no indication of non-compliance or misuse of medication. There is no evidence that this patient falls under a high risk category that would require frequent monitoring. Therefore, the request for a urinalysis cannot be determined as medically appropriate. As such, the request is non-certified.