

Case Number:	CM13-0043889		
Date Assigned:	12/27/2013	Date of Injury:	10/03/2009
Decision Date:	04/25/2014	UR Denial Date:	10/24/2013
Priority:	Standard	Application Received:	10/26/2013

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 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 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 65-year-old female who reported an injury on 10/3/09. The mechanism of injury was not stated. The patient is currently diagnosed with lumbar myoligamentous injury, bilateral lower extremity radiculopathy, cervical myoligamentous injury, and reactionary depression/anxiety. The patient was seen by [REDACTED] on 11/14/13. The patient reported severe and debilitating pain in the lower back with radiation to bilateral lower extremities. Physical examination on that date revealed tenderness in the posterior cervical musculature and suboccipital region, limited cervical range of motion, full range of motion of bilateral upper extremities, intact motor strength, decreased sensation along the lateral arm and forearm, positive Tinel's sign bilaterally, tenderness in the posterior lumbar musculature and sciatic notch region, limited lumbar range of motion, and diminished reflexes on the left. The patient also demonstrated positive straight leg raising on the left and decreased sensation in the L4 distribution. Treatment recommendations included continuation of current medications and a trial of spinal cord stimulation.

IMR ISSUES, DECISIONS AND RATIONALES

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

SPINAL CORD STIMULATION TRIAL: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 101,105,107.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 105-107.

Decision rationale: The California MTUS guidelines state that indications for stimulator implantation include failed back syndrome, complex regional pain syndrome, post-amputation pain, postherpetic neuralgia, spinal cord injury dysesthesia, pain associated with multiple sclerosis, and peripheral vascular disease. A psychological evaluation is also recommended prior to spinal cord stimulator trial. As per the documentation submitted, the patient does not maintain any of the above mentioned diagnoses. There is also no documentation of a psychological evaluation in which the patient has been cleared for a spinal cord stimulator trial. Therefore, the current request cannot be determined as medically appropriate. As such, the request is non-certified.

30 LIDODERM 5% PATCHES: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 57,66-67.

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

Decision rationale: The California MTUS guidelines state that lidocaine is indicated for neuropathic or localized peripheral pain after there has been evidence of a trial of first-line therapy. As per the documentation submitted, the patient was issued a prescription for Lidoderm 5% patch on 9/19/13. Despite the ongoing use of this medication, the patient presented on 11/14/13 with complaints of severe and debilitating pain with radiation to the bilateral lower extremities. Satisfactory response to treatment had not been indicated. Additionally, there was no evidence of a first-line trial of tricyclics or SNRI antidepressants or an anticonvulsant, as recommended by California MTUS guidelines. Based on the clinical information received and California MTUS guidelines, the request is non-certified.

30 FLECTOR PATCHES 1.3%: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 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. The only FDA-approved topical NSAID is Diclofenac. Diclofenac is indicated for the relief of osteoarthritis pain in joints that lend themselves to topical treatment. It has not been evaluated for treatment of the spine, hip, or shoulder. Therefore, the current request cannot be determined as medically appropriate. As such, the request is non-certified.

180 NORCO 10/325MG: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 80, 124.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 74-82.

Decision rationale: The California MTUS guidelines state that a therapeutic trial of opioids should not be employed until the patient has failed a trial of non-opioid analgesics. Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects should occur. As per the documentation submitted, the patient has utilized Norco 10/325mg since at least September 2013. Despite ongoing use of this medication, the patient continues to report severe and debilitating lower back pain with radiation to bilateral lower extremities. There is no change in the patient's physical examination that would indicate functional improvement. Based on the clinical information received and California MTUS guidelines, the request is non-certified.