MAXIMUS Federal Services

Case Number:	CM13-0045963		
Date Assigned:	12/27/2013	Date of Injury:	11/17/1988
Decision Date:	02/28/2014	UR Denial Date:	10/31/2013
Priority:	Standard	Application Received:	11/12/2013

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 chronic low back pain reportedly associated with an industrial injury of November 17, 1998. Thus far, the applicant has been treated with the following: Analgesic medications, adjuvant medications, attorney representation, prior lumbar epidural steroid injections in 2007, multiple, a cane, lumbar support, prior multiple lumbar spine surgeries, and unspecified amounts of psychotherapy. In a utilization review report of October 31, 2013, the claims administrator denied a request for a CT scan of the lumbar spine with contrast, denied a request for repeat electrodiagnostic testing, denied a request for Neurontin, and partially certified a request for Oxycodone for weaning purposes. Non-MTUS ODG Guidelines and non-MTUS 2007 ACOEM Guidelines were cited in conjunction with the CTs of cervical spine denial. The applicant's case and care have apparently been complicated by his continuing to smoke, it is further noted. A December 23, 2013 note is notable for comments that the applicant reports 9/10 low back pain. The applicant's medications are not working, it is stated. His activity levels are in fact decreased, it is stated. It is stated that the applicant is continuing to smoke every day. His BMI is 26. He exhibits an antalgic gait and markedly limited range of motion. It is stated that the applicant's referral to a neurosurgeon was denied. Current medications are renewed. An earlier note of November 19, 2013 states that the applicant has increased pain and weakness of the lower extremities and also exhibits decreased sensation about the same, positive straight leg raising, and an antalgic gait. An earlier note of October 22, 2013 was notable for comments that the applicant should obtain new imaging studies and repeat electrodiagnostic testing owing to heightened pain and numbness about the bilateral lower extremities. The applicant again exhibits an antalgic gait, altered lower extremity sensorium, and positive straight leg raising. The applicant's latest lumbar spine surgery was in 2000, it was further noted.

IMR ISSUES, DECISIONS AND RATIONALES

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

The request for 1 CT scan of the lumbar spine with contrast: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 59.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation In. Harris J (Ed), Occupational Medicine Practice Guidelines, 2nd Edition, table 12-7.

Decision rationale: As noted in the MTUS-adopted ACOEM Guidelines in chapter 12, table 12-7, CT scan imaging is scored at 3/4 in its ability to identify and define suspected disk protrusions and/or post laminectomy syndrome, both of which are reportedly present here. In this case, the applicant does seemingly have heightened low back and lower extremity radicular symptomatology with corresponding signs on exam. He is status post multiple prior lumbar spine surgeries. There may be some issues in metallic susceptibility artifact which make CT scanning superior to MRI imaging in this context. Accordingly, the original utilization review decision is overturned. The request is certified, on independent medical review.

The request for 1 repeat bilateral lower extremity electrodiagnostic study: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back - Lumbar & Throacic (Acute & Chronic).

MAXIMUS guideline: Decision based on MTUS ACOEM. Decision based on Non-MTUS Citation In. Harris J (Ed), Occupational Medicine Practice Guidelines, 2nd Edition (2004) - pp. 308-310.

Decision rationale: As noted in the MTUS-adopted ACOEM Guidelines in chapter 12, table 12-8, EMG testing is "not recommended" for a clinically obvious radiculopathy. In this case, the applicant seemingly has clinically obvious radiculopathy. CT scan imaging to definitively establish the source of the same has been endorsed above, in question #1. It will be more appropriate to determine the outcome of the same before considering potentially superfluous EMG testing here. Accordingly, the request remains non certified, on independent medical review.

The request for 1 prescription of Roxicodone 30mg #180: Upheld

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

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

Decision rationale: As noted on page 80 of the MTUS Chronic Pain Medical Treatment Guidelines, the cardinal criteria for continuation of opioid therapy includes evidence of successful return to work, improved functioning, and/or reduced pain effected as a result of ongoing opioid usage. In this case, however, the recent documentation, including the December 2013 progress note referenced above, suggests that the applicant is in fact having heightened pain complaints and heightened symptomatology. The applicant has failed to return to work. The applicant reports diminished ability to perform non-work activities of daily living and further reports diminished activity levels. All of the above, taken together, imply that ongoing usage of Roxicodone, an opioid, has been unsuccessful. Therefore, the request is not certified.

The request for 1 prescription of Neurontin 600mg #90: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation and Â§9792.20 Medical Treatment Utilization Schedule - Definitions.

Decision rationale: While Gabapentin or Neurontin is indicated as a first-line treatment for neuropathic pain, page 49 of the MTUS Chronic Pain Medical Treatment Guidelines suggests that Gabapentin or Neurontin is indicated as a first-line treatment for neuropathic pain, as is present here. In this case, the applicant does have ongoing neuropathic (radicular) complaints pertaining to the lumbar spine and lower extremities. However, page 19 of the MTUS Chronic Pain Medical Treatment Guidelines states that the recommended trial period for Gabapentin or Neurontin is three to eight weeks for titration and then one to two weeks of maximum tolerated dosage. In this case, however, the applicant has been using Gabapentin or Neurontin chronically, for well in excess of 3 to 10 weeks. There is, however, no evidence of functional improvement as defined by the parameters established in MTUS 9792.20f despite prior usage of Gabapentin or Neurontin. The applicant has failed to return to work. The applicant has failed to diminish reliance on medical treatment. The applicant remains highly reliant on various forms of medical treatment and diagnostic testing. Continued usage of Gabapentin or Neurontin in the face of the applicant's failure to exhibit functional improvement as defined by the parameters established in MTUS 9792.20f is not indicated. Therefore, the request is not certified.