MAXIMUS Federal Services

Case Number:	CM13-0054767		
Date Assigned:	12/30/2013	Date of Injury:	11/22/2009
Decision Date:	03/20/2014	UR Denial Date:	11/12/2013
Priority:	Standard	Application Received:	11/20/2013

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 Physical Medicine & 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 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 reports a date of injury of 11/22/2009. The listed diagnoses per [redacted] dated 10/01/2013 are: 1. Status post left shoulder surgery (date of surgery unknown). 2. Lumbar discopathy with radiculopathy. According to report dated 10/01/2013 by [redacted], the patient presents with constant radiating pain in the lower back with no improvement and intermediate slight pain in the left shoulder/arm. Examination of the lumbar spine shows there is tenderness to palpation with palpable spasm over the paraspinal muscles. Range of motion is restricted. There is sciatica noted over the left side. Examination of the left shoulder shows tenderness to palpation with palpable spasm. Full range of motion is noted. MRI of the lumbar spine dated 10/01/2013 reveals a 2-mm broad-based disk bulge at L4-L5 and L5-S1 with lateral hypertrophic facet degenerative changes. There is no herniated nucleus pulposus, neuroforaminal narrowing, or canal stenosis.

IMR ISSUES, DECISIONS AND RATIONALES

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

The request for urine toxicology: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Chapter, Urine drug testing (UDT)

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Urine Drug Testing

Decision rationale: The patient presents with continued pain in the lower back. Physician requests a urine toxicology. While MTUS does not specifically address how frequent UDSs should be obtained for various risk opiate users, ODG provides a clearer guideline. For low-risk opiate users, once yearly urine screen is recommended following initial screen within the first 6 months. In this case, medical records show patient was administered a UDS on 09/26/2013. The UDS reports positive for tramadol which is consistent with his tramadol prescriptions and there were no abnormal findings. The medical records show the patient was administered 3 UDSs in 2012. It does not appear, however, that the patient has had any other UDS than on 9/26/13. Once a year UDS is reasonable for someone on opiates. Recommendation is for authorization

The request for Fluriflex 180gm: Upheld

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

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

Decision rationale: The patient presents with continued complaints of lower back pain. The physician is requesting Fluriflex 180 mg. Fluriflex is a compound topical analgesic including flurbiprofen and cyclobenzaprine. The MTUS Guidelines regarding topical analgesics states "it is largely experimental in use with few randomized controlled trials to determine efficacy or safety. Any compounded product that contains at least one drug or drug class that is not recommended is not recommended." In this case, cyclobenzaprine is a muscle relaxant and is not recommended for any topical formulation. Recommendation is for denial as the compound cream contains at least one drug that is not recommended by guidelines

The request for TGHot 180gm: Upheld

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

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

Decision rationale: The patient presents with continued complaints of low back pain. The physician requests topical cream TGHot. TGHot is a compound topical cream containing tramadol, gabapentin, menthol camphor, and capsaicin. The MTUS Guidelines regarding topical analgesics states "it is largely experimental in use with few randomized controlled trials to determine efficacy or safety. Any compounded product that contains at least one drug or drug class that is not recommended is not recommended." Gabapentin is not recommended as a topical formulation. Therefore, the entire compounded formulation is not recommended. Recommendation is for denial.

The request for lumbar spine injection of Depomedrol 80mg IM and Kenalog 80mg IM: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines ESIs Page(s): 46-47.

Decision rationale: The patient presents with continued complaints of low back pain. Physician requests "lumbar spine injection ofpo-Medrol and Kenalog 80 mg." The physician does not specify the level of requested injection if this is to be an ESI in any of the reports provided for review 04/08/2013 to 10/01/2013. The MTUS Guidelines has the following regarding ESIs under chronic pain section page 46 and 47 "recommended as an option for treatment of radicular pain." In this case, examination did not find positive straight leg raise or dermatomal distribution of pain/paresthesia such as forearm to thumb/index, dorsal forearm to dorsum of hand, lateral thigh/calf (L5) anterior thigh/shin (L4) or posterior thigh/calf (S1). Furthermore, the MRI dated 10/01/2013 revealed mild disk bulges measuring 2 mm without compromise of the nerve roots. Bulging disks are not significant findings to cause radiculopathy. There are no EMG reports to confirm radiculopathy either. If this request is for just a muscle injection of steroids, there are no guidelines or medical evidence to support steroid injections for chronic back pain. Recommendation for the lumbar spine injection is not recommended.

The request for consultation for LINT Therapy: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Neuromuscular electrical stimulation (NMES devices).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Neuromuscular electrical stimulation (NMES devices) Page(s): 121.

Decision rationale: The patient presents for continued complaints of low back pain. Physician requests consultation for LINT therapy. Utilization review dated 11/12/2013 denied request stating "resources failed to reveal evidence-based support for its use." LINT is "localized intense neurostimulation therapy." The MTUS, ACOEM, and ODG Guidelines do not have any discussions on LINT specifically. However, for neuromuscular electrical stimulation, the MTUS Guidelines page 121 has the following "Not recommended. NMES is used primarily as part of a rehabilitation program following stroke and there is no evidence to support its use in chronic pain. There is no intervention trial suggesting benefit from NMES for chronic pain." In this case, there is no indication that this patient has had a stroke. Furthermore, the physician does not discuss how this treatment is intended to treat or relieve the patient's symptoms. The requested consultation for LINT therapy is not medically necessary and recommendation is for denial.

The request for acupuncture for 8 weeks: Upheld

Claims Administrator guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 8.

Decision rationale: This patient presents with continued complaints of low back pain. The physician requests "acupuncture of 8 weeks." Utilization review dated 11/12/2013 modified certification from "8 weeks" to 6 sessions. The MTUS Guidelines for acupuncture on page 8 "Recommends acupuncture for pain suffering and the restoration of function. Recommended frequency and duration is 3 to 6 treatments to produce functional improvement, 1 to three times per year with optimum duration of 1 to 2 months. Acupuncture treatments may be extended if functional improvement is documented as defined in section 9792.20(e); documentation of clinically significant improvement of ADL or reduction in work restrictions and decreased dependency on medical treatments." Given the patient's continued pain, a trial of 3 to 6 sessions of acupuncture may be warranted. However, the requested "8 weeks" without identifying the number of treatments requested is not medically necessary and recommendation is for denial.