MAXIMUS Federal Services

Case Number:	CM13-0064403		
Date Assigned:	01/03/2014	Date of Injury:	07/14/2011
Decision Date:	05/29/2014	UR Denial Date:	11/25/2013
Priority:	Standard	Application Received:	12/11/2013

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 Occupational Medicine, has a subspecialty in Preventive 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 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 claimant is a 44 year old male with date of injury 07/14/2011. The medical record associated with the request for authorization, an orthopedic qualified medical exam, dated 11/06/2013, lists subjective complaints as constant low back pain, which he rates as a 10/10 on the pain scale. His low back pain radiates down to the ankle and foot. He also reports a loss of motion, numbness, tingling, cramping, tension and spasms. Objective findings: An examination of the lower extremities revealed normal extremity alignment. He had decreased range of motion in the lumbar spine. Straight leg and Milgram's test were negative bilaterally. Tenderness on palpation was noted along the lumbar paraspinal muscles bilaterally with pain along the facets and pain with facet loading bilaterally. Diagnosis: 1. Discogenic lumbar condition with facet inflammation and radiculopathy with MRI demonstrating spondylosis at L5-S1, severe central canal stenosis at L3-4 and L4-5 2. Inguianal hernia on the left as a result of orthopedic injuries 3. Element of stress, depression, anxiety and sexual dysfunction as a result of orthopedic injuries for which we are requesting clarification and coverage. This is the patient's first and only visit with the requesting physician. Patient underwent an MRI of the lumbar spine on 11/12/2012 which revealed a posterocentral protrusion with annular tear at L1-L3. L3-S1 were noted for decreased height and hydration and mild stenosis due to foraminal disc bulge and facet arthrosis. There is no record in the documents provided for review to indicate the patient has undergone any previous physical therapy. The medical record documents the continued use of Norco, Terocin and Gabapentin since at least as far and back as 11/13/2012. There is no evidence the patient has previously been prescribed Tramadol, Protonix, or Lidopro. No SIG noted in the documents provided for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 GENERAL SURGEON CONSULTATION: 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), Hernia, Surgery.

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

Decision rationale: The Official Disability Guidelines state that watchful l waiting is an acceptable option for men with minimally symptomatic inguinal hernias. Delaying surgical repair until symptoms increase is safe because acute hernia incarcerations occur rarely. The medical record indicates that the patient is relatively asymptomatic in regard to his inguinal hernia. In addition, there is no mention of an inguinal hernia in any of the previous reports by other physicians, indicating that the patient has not been affected by the condition. The request for General surgery consultation is not medically necessary.

1 EMG OF THE BILATERAL LOWER EXTREMITIES: 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): 303.

Decision rationale: The ACOEM Guidelines state that electromyography (EMG), including H-reflex tests, may be useful to identify subtle, focal neurologic dysfunction in patients with low back symptoms lasting more than three or four weeks. Although the patient relates a history of S1 radiculopathy, the physical exam is completely devoid of signs of radiculopathy. The request for EMG of the bilateral lower extremities is not medically necessary.

1 NCV OF THE BILATERAL LOWER EXTREMITIES: 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), Low Back-Lumbar & Thoracic (Acute & Chronic).

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

Decision rationale: According to the Official Disability Guidelines, nerve conduction studies are not recommended. There is minimal justification for performing nerve conduction studies when a patient is presumed to have symptoms on the basis of radiculopathy, neurological testing

procedures have limited overall diagnostic accuracy in detecting disc herniation with suspected radiculopathy. The request for Nerve conduction studies of the bilateral lower extremities are not medically necessary.

12 PHYSICAL THERAPY SESSIONS: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 58.

Decision rationale: Therapeutic physical therapy for the low back is recommended as an option with authorization for a trial of 6 visits over 2 weeks, with evidence of objective functional improvement, prior to authorizing more treatments with a total of up to 18 visits over 6-8 weeks. There is no documentation that the patient has attended any of the previously approved visits as a trial or that he has had any objective functional improvement. The request for 12 physical therapy sessions are not medically necessary.

1 TENS UNIT: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Tens, Chronic Pain (Transcutaneous Electrotherapy)..

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 114-117.

Decision rationale: According to the MTUS, a one-month trial period of the TENS unit should be documented (as an adjunct to ongoing treatment modalities within a functional restoration approach) with documentation of how often the unit was used, as well as outcomes in terms of pain relief and function; rental would be preferred over purchase during this trial. Purchase of a TENS unit prior to a one-month trial period to assess its effectiveness is not medically necessary.

1 BACK BRACE: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 298.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 301.

Decision rationale: According to the MTUS, lumbar supports have not been shown to have any lasting benefit beyond the acute phase of symptom relief. The request for a back brace is not medically necessary.

NORCO 10/325 MG, #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Criteria for Use.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 74-94.

Decision rationale: The Chronic Pain Medical Treatment Guidelines state that continued or long-term use of opioids should be based on documented pain relief and functional improvement or improved quality of life. Despite the long-term use of Norco, the patient has reported very little, if any, functional improvement or pain relief over the course of the last year. The request for Norco 10/325 mg, #90 is not medically necessary.

TRAMADOL ER 150 MG, #30: Upheld

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

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

Decision rationale: The Chronic Pain Medical Treatment Guidelines state that continued or long-term use of opioids should be based on documented pain relief and functional improvement or improved quality of life. Tramadol is a centrally acting synthetic opioid analgesic and it is not recommended as a first-line oral analgesic. Tramadol can be added to the medication regimen, but as the immediate-release oral formulation, not as the extended-release formulation. There is no documentation supporting any functional improvement with the continued long-term use of opioids. The request for Tramadol ER 150 mg, #30 is not medically necessary.

GABAPENTIN 600 MG, #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines (May 2009), Gabapentin(Neurontin).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 19.

Decision rationale: Gabapentin is an anti-epilepsy drug which has been shown to be effective for treatment of diabetic painful neuropathy and postherpetic neuralgia and has been considered as a first-line treatment for neuropathic pain. An adequate trial period for gabapentin is three to eight weeks for titration, then one to two weeks at maximum tolerated dosage. With each office visit the patient should be asked if there has been a change in his pain symptoms, with the recommended change being at least 30%. There is no documentation that there has been a change in the patient's symptoms with gabapentin or any functional improvement. The request for Gabapentin is not medically necessary.

TEROCIN PATCHES, #20: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111-112..

Decision rationale: According to the MTUS, compounds containing lidocaine are not recommended for non-neuropathic pain. There is only one trial that tested 4% lidocaine for treatment of chronic muscle pain. The results showed there was no superiority over placebo. The patient's physical exam shows no evidence of radiculopathy or neuropathic pain. The request for Terocin patches are not medically necessary.

LIDOPRO LOTION 40Z: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines (May 2009), Capsaicin, Topical.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111-112.

Decision rationale: Lidopro lotion is a compounded medication which contains the following: Lidocaine 4.5%, Methyl Salicylate 27.5%, Menthol 10%, Capsaicin 0.0325%. It is classified by the FDA as a topical analgesic There is little to no research to support the use of many Compounded Topical Analgesics. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. As previously stated, according to the Chronic Pain Medical Treatment Guidelines, compounds containing lidocaine are not recommended for non-neuropathic pain. There is only one trial that tested 4% lidocaine for treatment of chronic muscle pain. The results showed there was no superiority over placebo. The patient's physical exam shows no evidence of radiculopathy or indications of neuropathic pain. The request is not Lidopro Lotion 4oz is not medically necessary.