

Case Number:	CM14-0007612		
Date Assigned:	02/07/2014	Date of Injury:	07/24/2013
Decision Date:	06/23/2014	UR Denial Date:	12/17/2013
Priority:	Standard	Application Received:	01/21/2014

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 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 patient is an [REDACTED] employee who has filed a claim for lumbar disc displacement associated with an industrial injury of July 24, 2013. Thus far, the patient has been treated with NSAIDs, opioids, Terocin patches, steroids, muscle relaxants, physical therapy, chiropractic therapy, home exercises, and TENS. Current medications include Zanaflex and Butrans patch. Review of progress notes low back pain with right lower extremity numbness and tingling. Findings include lumbar tenderness with paraspinal spasms, decreased lumbar range of motion with pain, positive straight leg raise test on the right, positive bilateral facet loading at levels of L5-S1, and decreased sensation and strength in the L5 and S1 distribution on the right. EMG/NCV of bilateral lower extremities dated September 23, 2013 showed normal results. Lumbar MRI showed mild to moderate facet arthropathy and discogenic degenerative changes resulting in L5-S1 3mm right paracentral disc protrusion without definite neural encroachment and mild bilateral foraminal stenosis; L3-4 and 4-5 mild to moderate bilateral foraminal stenosis secondary to broad-based annular bulge; and AP canal low range normal secondary to prominent epidural fat/lipomatosis. Utilization review dated December 17, 2013 indicates that the claims administrator denied a request for terocin patches as there is no documentation that there was failure of neuropathic pain medication; EMG/NCS of bilateral lower extremities as there are clear objective and imaging findings of radiculopathy; and modified certification for a trial of chiropractic therapy for 6 visits, and for hydrocodone/APAP 10/325mg for #34 as it was unclear whether opioid therapy provided significant improvement, patient was taking amounts beyond the daily recommended limit, and patient had concurrent use of alcohol.

IMR ISSUES, DECISIONS AND RATIONALES

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

TEROCIN PAIN PATCHES 1 BOX (10 PATCHES): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: CHRONIC PAIN MEDICAL TREATMENT GUIDELINES, ,

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: CHRONIC PAIN MEDICAL TREATMENT GUIDELINES, CHRONIC PAIN, 56-57, 112

Decision rationale: Terocin Patch contains 4% lidocaine and 4% menthol. According to Chronic Pain Medical Treatment Guidelines, topical lidocaine in the formulation of a dermal patch has been designated for orphans status by the FDA for neuropathic pain. In addition, Chronic Pain Medical Treatment Guidelines, states that topical lidocaine may be recommended for localized peripheral pain after there has been evidence of a trial of first-line therapy (tricyclic or SNRI anti-depressants or an AED such as gabapentin or Lyrica). In this case, there is no documentation regarding failure of or intolerance to first-line medications. Also, there is concurrent request and authorization for nortriptyline. There is no clear rationale as to the need of this medication at this time. Therefore, the request for Terocin patches is not medically necessary per the guideline recommendations of Chronic Pain Medical Treatment Guidelines.

HYDROCODONE/APAP 10/325MG #45: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: CHRONIC PAIN MEDICAL TREATMENT GUIDELINES, OPIOIDS,

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: CHRONIC PAIN MEDICAL TREATMENT GUIDELINES, CHRONIC PAIN, 78-81

Decision rationale: As noted on page 78-81 of the Chronic Pain Medical Treatment Guidelines, there is no support for ongoing opioid treatment unless there is ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. Patient has been on this medication since at least September 2013, and was discontinued as per progress note dated October 30, 2013 due to decreased efficacy. Progress notes indicate that patient has been taking up to 8-9 tablets per day, which exceeds guideline recommendations. Also, there is note that patient drinks 1-2 alcoholic drinks per day, which increases the risk for addiction and medication misuse. Patient has been on Butrans patches since, with note of 40% relief of pain temporarily, allowing increased activity level. There is no indication regarding the need for an additional opioid medication in this patient, especially one that showed minimal efficacy in the past. Therefore, the request for Hydrocodone/APAP was not medically necessary per the guideline recommendations of Chronic Pain Medical Treatment Guidelines.

EMG 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 MTUS: AMERICAN COLLEGE OF OCCUPATIONAL AND ENVIRONMENTAL MEDICINE PRACTICE GUIDELINES, 2ND EDITION, 2004, CHAPTER 12 (LOW BACK COMPLAINTS), 303

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back chapter, EMGs (electromyography).

Decision rationale: EMGs are indicated to identify subtle, focal neurologic dysfunction in patients with low back symptoms lasting more than three to four weeks. In addition, ODG states that EMGs may be useful to obtain unequivocal evidence of radiculopathy, after 1-month conservative therapy, but EMGs are not necessary if radiculopathy is already clinically obvious. Furthermore, NCVs are not recommended when symptoms are presumed to be on the basis of radiculopathy. In this case, patient has had EMG/NCV of bilateral lower extremities dated September 23, 2013 showing normal results. Since then, there has not been significant interval change in symptoms and findings. Symptoms, objective findings, and MRI results show evidence supporting underlying radiculopathy in this patient. There is no need for an additional diagnostic test at this time. Therefore, the requests for EMG of bilateral lower extremities are not medically necessary per the guideline recommendations of Chronic Pain Medical Treatment Guidelines, and ODG.

NCS OF 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.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back chapter, Nerve conduction studies (NCS).

Decision rationale: According to ODG, nerve conduction studies are not recommended when a patient is presumed to have symptoms on the basis of radiculopathy. In this case, patient has had EMG/NCV of bilateral lower extremities dated September 23, 2013 showing normal results. Since then, there has not been significant interval change in symptoms and findings. Symptoms, objective findings, and MRI results show evidence supporting underlying radiculopathy in this patient. There is no need for an additional diagnostic test at this time. Therefore, the request for NCS of bilateral lower extremities is not medically necessary per the guideline recommendations of ODG.

8 CHIROPRACTIC VISITS: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: CHRONIC PAIN MEDICAL TREATMENT GUIDELINES, MANUAL THERAPY AND MANIPULATION,

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: CHRONIC PAIN MEDICAL TREATMENT GUIDELINES, CHRONIC PAIN, 58

Decision rationale: Chronic Pain Medical Treatment Guidelines state that the goal is to achieve positive symptomatic or objective measurable functional improvement that facilitate progression in the patient's therapeutic exercise program and return to productive activities. A trial of 6 visits is recommended, and with evidence of objective functional improvement, a total of up to 18 visits are supported. In addition, elective/maintenance care is not medically necessary. In this case, there is documentation that the patient has undergone eight sessions of chiropractic therapy. It is unclear as to how many sessions the patient has already attended as utilization review dated December 17, 2013 provided authorization for 6 visits, and utilization review determination dated January 21, 2014 has already certified another 8 visits. Also, the requested body part is not specified. Therefore, the request for 8 chiropractic visits is not medically necessary.