

Case Number:	CM14-0130642		
Date Assigned:	08/20/2014	Date of Injury:	04/04/2008
Decision Date:	10/03/2014	UR Denial Date:	08/08/2014
Priority:	Standard	Application Received:	08/15/2014

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 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 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:

According to the records made available for review, this is a 44-year-old female with a 4/4/08 date of injury. At the time (7/29/14) of request for authorization for 10 Weeks Supervised ██████████ Weight Loss Program, 1 Replace: Cervical Spine Pillow; Jackson Roll; Right Wrist Brace, 1 Blood Work Kidney and Liver Function, 1 Single Positional MRI (Magnetic Resonance Imaging) of Lumbar Spine, EMG (Electromyography) and NCV (Nerve Conduction Velocity) RLE (Right Lower Extremity & LLE (Left Lower Extremity), Ultram ER (150mg, #60), Lyrica (75mg, #60), Cymbalta (60mg, #60), and Ultracin Topical Lotion 120ml, there is documentation of subjective (low back pain radiating to right lower extremity associated with numbness and tingling) and objective (tenderness over the right lumbar paravertebral muscles with spasm, decreased sensation over the L4-S1 dermatomes, and decreased lumbar range of motion) findings, imaging findings (reported MRI of the lumbar spine (9/9/11) revealed L4 through S1 disc protrusion) current diagnoses (lumbar spine sprain/strain with right lower extremity radiculopathy), and treatment to date (medications (including ongoing treatment with Ultram, Lyrica, and Cymbalta since at least 1/28/14) and physical therapy). Medical report identifies that the requested blood work is to monitor kidney and liver function secondary to long term medication use. In addition, medical report identifies that the rationale for the requested replacement Cervical Spine Pillow, Jackson Roll, and Right Wrist Brace is that the equipments are well worn and more than 6 months old.

IMR ISSUES, DECISIONS AND RATIONALES

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

Supervised [REDACTED] Weight Loss Program (10-weeks): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Pharmacologic Surgical Management of Obesity in Primary Care: A Clinical Practice Guideline From The American College of Physicians. Snow V, Barry P, Fitterman N, Qaseem A, Weiss K. Pharmacologic And Surgical Management Of Obesity In Primary Care: A Clinical Practice Guideline From The American College of Physicians. Ann Intern Med 23005 APR 5;142(7):525-31

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Aetna Company Policy Bulletin 0039 (http://www.aetna.com/cpb/medical/data/1_99/0039.html).

Decision rationale: The California MTUS Guidelines and the Official Disability Guidelines do not address the issue. Aetna identifies documentation of a documented history of failure to maintain weight at 20 % or less above ideal or at or below a BMI of 27 when the following criteria are met: BMI** greater than or equal to 30 kg/m; or a BMI greater than or equal to 27 and less than 30 kg/m and one or more of the following comorbid conditions: coronary artery disease, diabetes mellitus type 2, hypertension (systolic blood pressure greater than or equal to 140 mm Hg or diastolic blood pressure greater than or equal to 90 mm Hg on more than one occasion), obesity-hypoventilation syndrome (Pickwickian syndrome), obstructive sleep apnea, or dyslipidemia (HDL cholesterol less than 35 mg/dL; or LDL cholesterol greater than or equal to 160mg/dL; or serum triglyceride levels greater than or equal to 400 mg/dL, as criteria to support the medical necessity of a weight reduction program. Within the medical information available for review, there is documentation of a diagnosis of lumbar spine sprain/strain with right lower extremity radiculopathy. However, there is no documentation of a documented history of failure to maintain weight at 20% or less above ideal or at or below a BMI of 27 when the following criteria are met: BMI** greater than or equal to 30 kg/m; or a BMI greater than or equal to 27 and less than 30 kg/m and one or more of the following comorbid conditions: coronary artery disease, diabetes mellitus type 2, hypertension (systolic blood pressure greater than or equal to 140 mm Hg or diastolic blood pressure greater than or equal to 90 mm Hg on more than one occasion), obesity-hypoventilation syndrome (Pickwickian syndrome), obstructive sleep apnea, or dyslipidemia (HDL cholesterol less than 35 mg/dL ; or LDL cholesterol greater than or equal to 160 mg/dL; or serum triglyceride levels greater than or equal to 400 mg/dL. Therefore, based on guidelines and a review of the evidence, the request for a Supervised [REDACTED] Weight Loss Program is not medically necessary.

Replace DME: cervical spine pillow; Jackson roll; and right wrist brace: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints, Chapter 8 Neck and Upper Back Complaints Page(s): 175 , 264-265. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee, Durable medical equipment (DME).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee, Durable medical equipment (DME)

Decision rationale: The California MTUS Guidelines do not address this issue. The Official Disability Guidelines identifies documentation that the requested durable medical equipment (DME) can withstand repeated use (i.e. could normally be rented, and used by successive patients); and is primarily and customarily used to serve a medical purpose, generally is not useful to a person in the absence of illness or injury, as criteria necessary to support the medical necessity of durable medical equipment. In addition, medical practice standard of care necessitate documentation of a clear rationale for the replacement of DME already in use, such as malfunction or breakdown. Within the medical information available for review, there is documentation of a diagnosis of lumbar spine sprain/strain with right lower extremity radiculopathy. However, despite documentation that the rationale for the requested replacement Cervical Spine Pillow, Jackson Roll, and Right Wrist Brace is that the equipments are well worn and more than 6 months old, there is no documentation of a clear rationale for the replacement of DME already in use (malfunction or breakdown). Therefore, based on guidelines and a review of the evidence, the request for to replace a cervical spine pillow; Jackson roll; and right wrist brace is not medically necessary.

Kidney and Liver Function Test: Overturned

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Medical Necessity of Laboratory Tests (http://www.healthcarecompliance.info/med_nec.htm)

Decision rationale: The California MTUS Guidelines and the Official Disability Guidelines do not address the issue. Medical Treatment Guideline necessitate documentation of a clearly stated rationale identifying why laboratory tests are needed, as criteria necessary to support the medical necessity of blood tests. Within the medical information available for review, there is documentation of a diagnosis of lumbar spine sprain/strain with right lower extremity radiculopathy. In addition, given documentation that the requested blood work is to monitor kidney and liver function secondary to long term medication use, there is documentation of a clearly stated rationale identifying why laboratory tests are needed. Therefore, based on guidelines and a review of the evidence, the request for Kidney and Liver Function test is medically necessary.

Single Positional Magnetic Resonance Imaging (of the lumbar spine): Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303, 53.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-304. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Minnesota Rules, 5221.6100 Parameters for Medical Imaging

Decision rationale: The ACOEM Practice Guidelines identifies documentation of red flag diagnoses where plain film radiographs are negative; objective findings that identify specific nerve compromise on the neurologic examination, failure of conservative treatment, and who are considered for surgery, as criteria necessary to support the medical necessity of MRI. The Official Disability Guidelines identifies documentation of a diagnosis/condition (with supportive subjective/objective findings) for which a repeat study is indicated (such as: To diagnose a suspected fracture or suspected dislocation, to monitor a therapy or treatment which is known to result in a change in imaging findings and imaging of these changes are necessary to determine the efficacy of the therapy or treatment (repeat imaging is not appropriate solely to determine the efficacy of physical therapy or chiropractic treatment), to follow up a surgical procedure, to diagnose a change in the patient's condition marked by new or altered physical findings) as criteria necessary to support the medical necessity of a repeat MRI. Within the medical information available for review, there is documentation of a diagnosis of lumbar spine sprain/strain with right lower extremity radiculopathy. In addition, there is documentation of a September 9, 2011 MRI of the lumbar spine. However, despite documentation of subjective (low back pain radiating to right lower extremity associated with numbness and tingling) and objective (tenderness over the right lumbar paravertebral muscles with spasm, decreased sensation over the L4-S1 dermatomes, and decreased lumbar range of motion) findings, there is no documentation of diagnosis/condition (with supportive subjective/objective findings) for which a repeat study is indicated (to diagnose a suspected fracture or suspected dislocation, to monitor a therapy or treatment which is known to result in a change in imaging findings and imaging of these changes are necessary to determine the efficacy of the therapy or treatment, to follow up a surgical procedure, to diagnose a change in the patient's condition marked by new or altered physical findings). Therefore, based on guidelines and a review of the evidence, the request for a single positional MRI is not medically necessary.

Electromyogram and Nerve Conduction Velocity (of the right lower extremity & the left lower extremity): 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 (ODG) Low Back, Electrodiagnostic studies.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 303. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back, Electrodiagnostic studies

Decision rationale: The ACOEM Practice Guidelines identifies documentation of focal neurologic dysfunction in patients with low back symptoms lasting more than three to four weeks, as criteria necessary to support the medical necessity of electrodiagnostic studies. The Official Disability Guidelines identifies documentation of evidence of radiculopathy after 1-month of conservative therapy, as criteria necessary to support the medical necessity of

electrodiagnostic studies. In addition, ODG does not consistently support performing nerve conduction studies when a patient is presumed to have symptoms on the basis of radiculopathy. Furthermore, the ODG identifies that electromyogram is useful in cases where clinical findings are unclear; there is a discrepancy in imaging, or to identify other etiologies of symptoms. Within the medical information available for review, there is documentation of a diagnosis of lumbar spine sprain/strain with right lower extremity radiculopathy. In addition, given documentation of objective (decreased sensation over the L4-S1 dermatomes) findings, there is documentation of focal neurologic dysfunction with low back symptoms lasting more than three to four weeks. Furthermore, there is documentation of 1-month of conservative treatment. However, given documentation of an associated request for an MRI of the lumbar spine, there is no documentation that the MRI or other diagnostic studies do not explain the etiology of the radicular symptoms. Therefore, based on guidelines and a review of the evidence, the request for an electromyogram and nerve conduction velocity of the right lower extremity and left lower extremity is not medically necessary.

Ultram ER (150mg, #60): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Ultram (Tramadol).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74-80, 113. Decision based on Non-MTUS Citation Title 8, California Code of Regulations, section 9792.20

Decision rationale: The Chronic Pain Medical Treatment Guidelines identifies documentation that the prescriptions are from a single practitioner and are taken as directed; the lowest possible dose is being prescribed; and there will be ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects; as criteria necessary to support the medical necessity of Opioids. In addition, specifically regarding Tramadol, guideline identifies documentation of moderate to severe pain and Tramadol used as a second-line treatment (alone or in combination with first-line drugs), as criteria necessary to support the medical necessity of Tramadol. California MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. Within the medical information available for review, there is documentation of a diagnosis of lumbar spine sprain/strain with right lower extremity radiculopathy. In addition, there is ongoing treatment with Ultram. However, there is no documentation that the prescriptions are from a single practitioner and are taken as directed; the lowest possible dose is being prescribed; and there will be ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. In addition, there is no documentation of Ultram used as a second-line treatment (alone or in combination with first-line drugs). Furthermore, there is no documentation of moderate to severe pain. Lastly, there is no documentation of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications as a result of Ultram use to date. Therefore, based on guidelines and a review of the evidence, the request for Ultram ER is not medically necessary.

Lyrica (75mg, #60): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Lyrica (pregabalin).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Pregabalin (Lyrica) Page(s): 19-20. Decision based on Non-MTUS Citation Title 8, California Code of Regulations, section 9792.20

Decision rationale: The Chronic Pain Medical Treatment Guidelines identifies documentation of neuropathic pain, as criteria necessary to support the medical necessity of Lyrica. The California MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. Within the medical information available for review, there is documentation of a diagnosis of lumbar spine sprain/strain with right lower extremity radiculopathy. In addition, there is documentation of ongoing treatment with Lyrica. Furthermore, given documentation of subjective (low back pain radiating to right lower extremity associated with numbness and tingling) findings and a diagnosis of lumbar spine sprain/strain with right lower extremity radiculopathy, there is documentation of neuropathic pain. However, there is no documentation of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications as a result of Lyrica use to date. Therefore, based on guidelines and a review of the evidence, the request for Lyrica is not medically necessary.

Cymbalta (60mg, #60): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Cymbalta (duloxetine)..

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Duloxetine (Cymbalta) Page(s): 43-44. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chronic Pain Chapter, Antidepressants for chronic pain MTUS Title 8, California Code of Regulations, section 9792.20

Decision rationale: The Chronic Pain Medical Treatment Guidelines state Cymbalta is a norepinephrine and serotonin reuptake inhibitor antidepressant (SNRIs). In addition, MTUS Chronic Pain Medical Treatment Guidelines identifies documentation of depression, generalized anxiety disorder, or pain related to diabetic neuropathy, as criteria necessary to support the medical necessity of Cymbalta. The California MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. Within the medical information available for review, there is documentation of a diagnosis of lumbar spine sprain/strain with right lower extremity radiculopathy. In addition, there is documentation of ongoing treatment with Cymbalta.

However, there is no documentation of depression, generalized anxiety disorder, or pain related to diabetic neuropathy. In addition, there is no documentation of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications as a result of Cymbalta use to date. Therefore, based on guidelines and a review of the evidence, the request for Cymbalta is not medically necessary.

Ultracin Topical Lotion, 120ml,: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Ultracin lotion (Methyl salicylate, menthol & capsaicin).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-112. Decision based on Non-MTUS Citation website Drugs.com (<http://www.drugs.com/otc/121647/ultracin.html>)

Decision rationale: An online search identifies that Ultracin contains Menthol, Methyl salicylate, and Capsaicin. The Chronic Pain Medical Treatment Guidelines identifies documentation of neuropathic pain when trial of antidepressants and anticonvulsants have failed, as criteria necessary to support the medical necessity of topical analgesics. Within the medical information available for review, there is documentation of a diagnosis of lumbar spine sprain/strain with right lower extremity radiculopathy. However, there is no documentation of neuropathic pain when trial of antidepressants and anticonvulsants have failed. Therefore, based on guidelines and a review of the evidence, the request for Ultracin Topical Lotion is not medically necessary.