

Case Number:	CM14-0136356		
Date Assigned:	09/03/2014	Date of Injury:	04/13/2013
Decision Date:	09/30/2014	UR Denial Date:	07/25/2014
Priority:	Standard	Application Received:	08/25/2014

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 Internal Medicine, Pulmonary Diseases, 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 injured worker is a 58-year-old female who reported an injury on 04/13/2013. The mechanism of injury was not provided. An EMG /NCV performed on 2/06/2014 revealed no electro diagnostic evidence of focal nerve entrapment, lumbar radiculopathy, or generalized neuropathy affecting the lower limbs. On 08/13/2014, the injured worker presented with mid and low back pain. Prior treatment included chiropractic care, physical therapy, and acupuncture. Current medications included Norco, Flexeril, and Lidopro cream. Upon examination, there was tenderness to palpation over the lower spine extending into the bilateral paraspinal region, right greater than left. The range of motion was decreased with diminished sensation over the left L5 and S1 dermatomes. There was a positive right sided straight leg raise and 4+/5 strength to the right hamstring, TA, EHL, and inversion. MRI of the lumbar spine performed on 03/28/2014 revealed diffuse disc herniation at L5-S1 which causes stenosis of the spinal canal and bilateral recess. The diagnoses were HNP of the lumbar spine, lumbar radiculopathy, and HNP of the thoracic spine. The provider recommended a transforaminal ESI on the right L5-S1, Hydrocodone, Cyclobenzaprine, and Lidopro Topical Ointment; the provider's rationale was not provided. The request for authorization form was dated 4/21/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

TFESI on the Right at L5-S1: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injections Page(s): 46.

Decision rationale: The request for TFESI on the right at L5-S1 is not medically necessary. According to California MTUS Guidelines, an Epidural Steroid Injection may be recommended to facilitate progress in more active treatment programs when there is radiculopathy documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. Additionally, documentation should show that the injured worker was initially unresponsive to conservative treatment. Injections should be performed using fluoroscopy for guidance and no more than 2 root levels should be injected using transforaminal blocks. Documentation submitted for review stated the injured worker completed initially recommended conservative treatment, but continued to complain of radiating pain in the right lower extremity. A prior EMG noted no electrodiagnostic evidence of focal nerve entrapment, lumbar radiculopathy, or generalized peripheral neuropathy affecting the lower limbs. There was tenderness to palpation on the lumbar spine ascending into the bilateral paraspinal regions, diminished sensation in the L5-S1 dermatomes, and a positive right sided straight leg raise. The physical examination findings and diagnostic testing findings do not clearly corroborate radiculopathy. In addition, the documentation failed to show that the injured worker would be participating in an active treatment program following the requested injections. Based on the above information, the request is not medically necessary.

120 Hydrocodone/APAP 10/325mg: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 78.

Decision rationale: The request for 120 Hydrocodone/APAP 10/325mg is not medically necessary. The California MTUS Guidelines recommend the use of opioids for ongoing management of chronic pain. The guidelines recommend ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects should be evident. There is lack of evidence of an objective assessment of the injured worker's pain level, functional status, evaluation of risk for aberrant drug abuse, behavior, and side effects. Additionally, the efficacy of the prior use of the medication was not provided. The provider does not state the frequency of the medication in the request as submitted. As such, the request is not medically necessary.

30 Cyclobenzaprine (Flexeril) 7.5mg: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Cyclobenzaprine (Flexeril) Page(s): 41.

Decision rationale: The request for 30 Cyclobenzaprine (Flexeril) 7.5mg is not medically necessary. The California MTUS Guidelines recommend Cyclobenzaprine as an option for a short course of therapy. The greatest effect of the medication is in the first 4 days of treatment, suggesting that shorter courses may be better and that treatment should be brief. The provided medical records lacked documentation of significant objective functional improvement with the use of this medication. The provider's rationale was not provided. The provider does not state the frequency of the medication in the request as submitted. As such, the request is not medically necessary.

LidoPro topical ointment 4oz: Upheld

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

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

Decision rationale: The request for LidoPro Topical Ointment 4oz is not medically necessary. The California MTUS Guidelines state that transdermal compounds are largely experimental in use with few randomized controlled trials to determine efficacy or safety. Topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Any compounded product that contains at least one drug or drug product that is not recommended is not recommended. The guidelines note is the only topical formulation of Lidocaine that is recommended. There is a lack of documentation of a failed trial of an antidepressant or an anticonvulsant. Additionally, the provider's request does not indicate the site that the cream is indicated for, the frequency or the quantity in the request as submitted. As such, the request is not medically necessary.