

Case Number:	CM14-0020595		
Date Assigned:	04/30/2014	Date of Injury:	07/08/2013
Decision Date:	07/08/2014	UR Denial Date:	02/13/2014
Priority:	Standard	Application Received:	02/19/2014

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 & Pain Management, has a subspecialty in Pain Medicine and is licensed to practice in Oklahoma and Texas. 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 38 year old male that reported a lifting injury to his lower back on 07/08/2013. Within the clinical note dated 03/05/2014 the injured worker reported constant low back pain rated 6-7/10 without his medication and also had numbness and tingling bilaterally to his hips. The clinical note reported the injured worker had an epidural steroid injection on 02/18/2014 and reported an immediate reduction in pain from 9/10 to 8/10. The physical exam noted the injured worker had intact deep tendon reflexes in the lower extremities and the injured worker had loss of dermatomal sensation in the lower extremities. After the epidural steroid injection lumbar spine flexion was 50 degrees, extension was 20 degrees, lateral bending was 20 degrees, rotation was 30 degrees. The official MRI dated 08/08/2013 reported at the L5-S1 disc level the neural foramina were patent. Within the chiropractic note dated 07/15/2013 the injured worker reported active range of motion in the lumbar spine with flexion to 40 degrees, extension to 15 degrees, lateral flexion to 15 degrees, right rotation to 15 degrees, left rotation to 10 degrees. The injured worker, within the chiropractic note, reported normal dermatomal sensation along the entire lower extremities. The request for authorization was dated 03/17/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

FIRST DIAGNOSTIC LUMBAR EPIDURAL STEROID INJECTION AT DISC LEVELS L4-L5 AND 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 CA MTUS guidelines note radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electro-diagnostic testing. Additionally, the injured worker should have documentation of being initially unresponsive to conservative treatment (exercises, physical methods, NSAIDs and muscle relaxants). Injections should be performed using fluoroscopy (live x-ray) for guidance. The injured worker had conflicting range of motion values between the primary care physician and the chiropractic physical evaluations and along the dermatomal sensations. Also, the guidelines recommend the procedure be done under fluoroscopy and there was not an outline within the documentation that would utilize the imaging. Additionally, the diagnosis needed to be confirmed by either imaging or electrical studies and the provided MRI did not validate the objective findings nor the diagnosis. Lastly, it is unclear in the submitted documentation whether any physical therapy has been utilized. Hence, there is a lack of documentation that there has been an exhaustion of conservative care. The provider did not include adequate documentation of significant findings of radiculopathy upon physical examination. Thus, the request is non-medically necessary and appropriate.

CLEARANCE FROM INTERNAL MEDICINE: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation AMERICAN COLLEGE OF OCCUPATIONAL AND ENVIRONMENTAL MEDICINE (ACOEM), 2ND EDITION, (2004) FOUNDATION CHAPTERS, INDEPENDENT MEDICAL EXAMINATIONS AND CONSULTATIONS.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation AMERICAN COLLEGE OF OCCUPATIONAL AND ENVIRONMENTAL MEDICINE (ACOEM), 2ND EDITION, (2004) FOUNDATION CHAPTERS, INDEPENDENT MEDICAL EXAMINATIONS AND CONSULTATIONS.

Decision rationale: The provided requested a clearance from internal medicine for the epidural steroid injections. The requested lumbar epidural steroid injection would not be indicated at this time. As such, the requested clearance from internal medicine would not be medically necessary. Therefore, the request is not medically necessary and appropriate.

PSYCHOLOGICAL EVALUATION: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Psychological treatment Page(s): 102-103.

Decision rationale: The physician's rationale for the request was to determine if the injured worker could emotionally undergo the procedure, but the injured worker has already undergone the procedure 02/18/2014; the requested lumbar epidural steroid injection would not be indicated at this time. The injured worker did not appear to have significant psychological issues which would require an evaluation. As such, the requested psychological evaluation would not be medically necessary. Therefore, the request is not medically necessary and appropriate.

MEDICAL COMPOUND CREAM: KETOPROFEN 10% / CYCLOBENZAPRINE 3% / LIDOCAINE 5% - 120g - WITH 3 REFILLS (3 TUBES DISPENSED IN OFFICE):
Upheld

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

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

Decision rationale: The CA MTUS guidelines recommend topical lidocaine, in the formulation of a dermal patch has been designated for orphan status by the FDA for neuropathic pain. Lidoderm is also used off-label for diabetic neuropathy. No other commercially approved topical formulations of lidocaine (whether creams, lotions or gels) are indicated for neuropathic pain. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. The guidelines note the topical application of muscle relaxants is not recommended. Lidopro contains lidocaine in a gel form which contraindicates the guideline recommendations. Additionally, the medication contains a muscle relaxant which would not be congruent with the guideline recommendations. Thus, the request is not medically necessary and appropriate.