

Case Number:	CM14-0040052		
Date Assigned:	06/27/2014	Date of Injury:	03/30/2011
Decision Date:	08/18/2014	UR Denial Date:	03/12/2014
Priority:	Standard	Application Received:	04/04/2014

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 & Rehabilitation, has a subspecialty in Pain 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 patient is a 57-year-old female with a 3/30/11 date of injury. 3/12/14 determination letter recommended modified to medication for lumbar epidural steroid injection (ESI) on the right at L3-4, 30 day trial of transcutaneous electrical nerve stimulation (TENS) unit, and one-month trial of Flector patch 1.3%. It was noted that the patient injured herself when she tripped and fell forward onto her face, knees, and hands. On 3/5/14, there was a documentation of persistent low back pain. Clinically, there was note of radiculopathy. 1/3/14 progress note described 4-8/10 low back pain, occasional giving way of the knees, and occasional bowel/bladder incontinence. There are sleep difficulties secondary to pain. Clinically, there is reduced range of motion in the cervical and lumbar spine, sensory loss in the right leg with numbness at the right lateral hip region. Straight leg raising (SLR) was positive on the right. Additional medical records included 4/9/14 progress note that stated the patient underwent lumbar fusion at L3-4 (2013) and was doing extremely well initially. However, pain has increased in the low back with occasional radiation to the buttocks. There was noted stenosis at L2-3 on magnetic resonance imaging (MRI). It was noted that injections have been requested on multiple occasions. Clinically, there was mild tenderness over the midline lumbar spine at L4-5 and L5-S1; 5/5 motor strength; and negative SLR. Computed tomography (CT) scan from 3/26/14 reportedly revealed grade 1 spondylolisthesis at L3-4 with only mild amount of bone growth indicated. There was no significant lucency around the screws. Treatment plan discussed lumbar epidural steroid injection (ESI).

IMR ISSUES, DECISIONS AND RATIONALES

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

Lumbar Epidural Steroid Injection (LESI) Right L3-4: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300, Chronic Pain Treatment Guidelines Epidural Steroid Injections Page(s): 46. Decision based on Non-MTUS Citation American Medical Association Guides, Radiculopathy.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300, Chronic Pain Treatment Guidelines Transforaminal Approach Page(s): 46. Decision based on Non-MTUS Citation American Medical Association Guides, Radiculopathy.

Decision rationale: Medical necessity for the requested lumbar ESI is established. This request was previously certified due to ongoing low back pain with radiculopathy, failure of conservative treatment, occasional bowel/bladder incontinence, as well as giving way of the lower extremities. Imaging confirmed stenosis. Guidelines support lumbar ESI when there is clinical evidence of radiculopathy, supporting imaging findings, and failure of conservative treatment. The patient underwent lumbar fusion at L3-4, has had 42 sessions of postoperative physical therapy, and yet remains significantly symptomatic with possible myelopathic findings. The requested is medically necessary.

TENS unit: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS Units Page(s): 114, 116.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS (Transcutaneous Electrical Nerve Stimulation) Page(s): 114.

Decision rationale: Medical necessity for the requested TENS unit is established. This request was certified, as there was evidence of attempts at conservative treatment including 42 sessions of postoperative physical therapy (PT). Lumbar ESI was recommended to reduce pain and local inflammation, as well as to address radiculitis. Guidelines support a TENS unit when there has been failure of other conservative treatments. The patient is status post L3-4 lumbar decompression and fusion, followed by a 42 sessions of physical therapy following surgery. The use of a TENS unit for additional pain management is medically necessary.

Topical cyclobenzaprine 2% cream (quantity unknown): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111, 112-113.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Medications Page(s): 111-113.

Decision rationale: Medical necessity for the requested topical cyclobenzaprine cream is not established. CA MTUS Chronic Pain Medical Treatment Guidelines state that baclofen and other muscle relaxants are not recommended for topical applications. In addition, any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Within the context of this appeal it has not been discussed why the patient requires a topical medication that is not guideline supported. The request is not medically necessary.

Flector patch 1.3% (quantity unknown): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Non-steroidal anti-inflammatory agents (NSAIDs) Page(s): 111-112. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Chapter, Flector Patches.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-112. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Chapter, Flector Patches.

Decision rationale: Medical necessity is not established for the requested Flector patch. The prior request was certified for a one-month trial in order to establish efficacy. CA MTUS states that topical NSAIDs have a diminishing effect over a 2-week period. In addition, the Official Disability Guidelines (ODG) states that Flector is recommended for osteoarthritis after failure of oral NSAIDs or contraindications to oral NSAIDs. The patient has gastritis and is unable to utilize oral NSAIDs, however the request does not specify a quantity and the request as specified cannot be medically necessary.