

Case Number:	CM14-0060360		
Date Assigned:	07/11/2014	Date of Injury:	08/09/2007
Decision Date:	09/12/2014	UR Denial Date:	04/18/2014
Priority:	Standard	Application Received:	05/01/2014

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 Medicine and is licensed to practice in Texas and Oklahoma. 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 female who reported an injury on 08/09/2007. The mechanism of injury was not provided with the documentation submitted with this review. Her diagnosis was noted to be displacement of lumbar intervertebral disc without myelopathy. Prior treatments were noted to be acupuncture, epidural steroid injections, and medications. She had an MRI of the lumbar spine. This MRI showed a previous interbody fusion at L4-5 and L5-S1 disc levels. The injured worker had a clinical evaluation on 04/10/2014. Her subjective complaints were noted to be radiating pain down right lower extremity all the way to her toes. Her medications were noted to be vitamins and Pepcid. The objective physical exam findings include restriction and pain in the lumbar spine. Muscle guarding was noted and decreased sensation to light touch, pinprick and temperature in the right leg along the L4, L5, and S1 dermatomes. Her deep tendon reflexes on the right side were diminished at 1+ right knee, 2+ left knee, 1+ bilateral ankle. Motor strength was 5/5 bilaterally. The treatment plan was for Voltaren gel and Lidoderm patches. The request for authorization form was within the review and dated 04/10/2014. The provider's rationale was noted within the clinical note on 04/10/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Voltaren Topical gel 1% 2g no refills: Upheld

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

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

Decision rationale: The request for Voltaren topical gel 1% 2 g no refills is non-certified. The California MTUS Chronic Pain Medical Treatment Guidelines indicate Voltaren gel for relief of osteoarthritis pain in joints that lend themselves to topical treatment such as ankle, elbow, foot, hand, knee, and wrist. He has not been evaluated for treatment of the spine, hip, or shoulder. In addition, the guidelines state topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. They are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. The provider has noted in the treatment plan that the Voltaren gel is for the lumbar spine. The treatment plan does not indicate failed trials of antidepressants and anticonvulsants. In addition, the provider's request fails to indicate a dosage frequency. Therefore, the request for Voltaren topical gel 1% 2 g no refills is not medically necessary.

Lidoderm patches 5% x 5 refills: Upheld

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

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

Decision rationale: The request for Lidoderm patches 5% x 5 refills is non-certified. The California MTUS Chronic Pain Medical Treatment Guidelines state topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. These are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. 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. The documentation provided does not indicate failed trials of gabapentin or Lyrica. In addition, the provider's request fails to indicate a dosage frequency and application site. As such, the request for Lidoderm patches 5% x 5 refills is not medically necessary.

H-Wave unit: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines H-wave stimulation (HWT).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines H-wave stimulation (HWT) Page(s): 117-118.

Decision rationale: The request for H-wave unit is non-certified. The California MTUS Chronic Pain Medical Treatment Guidelines do not recommend H-wave stimulation as an isolated intervention, but a one month home-based trial of H-wave stimulation may be

considered as a noninvasive conservative option for diabetic neuropathic pain or chronic soft tissue inflammation if used as an adjunct to a program of evidence based functional restoration, and only following failure of initially recommended conservative care, including transcutaneous electrical nerve stimulation, recommended physical therapy and medications. The documentation submitted for review does not indicate use of the H-wave system with an adjunct program of evidence based functional restoration. In addition, it is not noted that the injured worker has had adequate conservative care and documented failure. In addition, the provider's request does not support the one month trial. As such, the request for H-wave unit is not medically necessary.

Lumbar Epidural Steroid Injection (ESI) right sided and Transforaminal ESI (TFESI) L4, 5, S1 x 2 wks apart: Upheld

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

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

Decision rationale: The request for lumbar epidural steroid injection (ESI) right-sided and transforaminal ESI (TEFSI) L4, 5, S1 x2 weeks apart is non-certified. The California MTUS Chronic Pain Medical Treatment Guidelines recommend epidural steroid injections as an option for treatment of radicular pain. The guidelines recommend no more than 2 ESI injections. The Official Disability Guidelines recommend epidural steroid injections as a possible option for short-term treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy) with use in conjunction with active rehab efforts. The purpose of an epidural steroid injection is to reduce pain and inflammation, thereby facilitating progress in more active treatment programs, reduction of medication use, and avoiding surgery, but this treatment alone offers no significant long-term functional benefit. The criteria for an epidural steroid injection according to the Guidelines is (1) radiculopathy must be documented. Objective findings on examination need to be present; (2) initially unresponsive to conservative treatment of exercises, physical methods, NSAIDs, and muscle relaxants; (3) injections should be performed using fluoroscopy and injection of contrast for guidance. The Guidelines continue to recommend no more than 2 nerve root levels should be injected using transforaminal blocks. The injured worker just had an ESI on 03/27/2014. A request for 2 additional is in excess of the guidelines. Failed conservative care is not documented. In addition, the request fails to indicate the use of fluoroscopy for guidance. Therefore, the request for lumbar epidural steroid injection (ESI) right-sided and transforaminal ESI (TEFSI) L4, 5, S1 x 2 weeks apart is not medically necessary.