

Case Number:	CM14-0061134		
Date Assigned:	08/08/2014	Date of Injury:	07/14/1992
Decision Date:	09/17/2014	UR Denial Date:	04/11/2014
Priority:	Standard	Application Received:	05/02/2014

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 Orthopedic Spine Surgery and is licensed to practice in 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 47-year-old male who reported an injury on 07/14/1992. The mechanism of injury involved a fall. Current diagnoses include postlaminectomy syndrome, lumbar disc disease, lumbar radiculitis, and sacroilitis. The injured worker was evaluated on 02/24/2014 with complaints of persistent lower back pain. It is noted that the injured worker underwent a lumbar discectomy in 1992 and in 2001, as well as a posterior lumbar interbody fusion in 12/2006 with an exploration in 2008. The injured worker is also status post repeat bilateral L4-S1 laminectomy and discectomy on 05/25/2011. The injured worker underwent a spinal cord stimulator trial and declined a permanent implantation. The current medication regimen includes Norco, Prilosec, orphenadrine, fentanyl, Lunesta, Lyrica, Cialis, Wellbutrin, and Xanax. Physical examination revealed no acute distress, a slow and altered gait, well healed surgical scars, tenderness over the bilateral paraspinal muscles with spasm, tenderness over the thoracic spine, limited lumbar range of motion, diminished reflexes in the bilateral lower extremities, positive straight leg raise bilaterally, decreased sensation of the right medial thigh and calf, and weakness in the lower extremities. It is noted that the injured worker underwent a lumbar CT scan on 10/11/2013, an MRI scan of the lumbar spine on 12/08/2010, electrodiagnostic studies in 2007 and 2009, and an x-ray of the lumbar spine in 2008. Treatment recommendations at that time included a prescription for fentanyl patch 12 mcg and an SI joint fusion. A request for authorization form was then submitted on 03/03/2014 for a bilateral joint fusion with an inpatient stay for 2 days, preoperative EKG, lab work, assistant surgeon, and a prescription for fentanyl patches.

IMR ISSUES, DECISIONS AND RATIONALES

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

Bilateral joint fusion: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Hip & Pelvis Chapter, Sacroiliac Joint Fusion.

Decision rationale: The Official Disability Guidelines state indications for an SI joint fusion include post-traumatic injury of the SI joint, failure of nonoperative treatment, chronic pain, diagnosis confirmed by pain relief with an intra-articular sacroiliac joint injection under fluoroscopic guidance, and following an assessment of preoperative and postoperative general health and function. Medical records and plain films should be reviewed retrospectively to determine the clinical and radiographic outcome. As per the documentation submitted, there is no evidence of pain relief following an intra-articular sacroiliac joint injection under fluoroscopic guidance. Therefore, the injured worker does not meet criteria for the requested procedure. The specific body part was also not listed in the current request. As such, the request is not medically necessary.

Inpatient 2 days: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation <http://www.ncbi.nlm.nih.gov/pubmed/1135047>.

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

EKG and lab work: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines.

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

Assistant surgeon: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines.

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

Flurbiprofen 20% cream 30gm: Upheld

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

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

Decision rationale: California MTUS Guidelines state topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. The only FDA approved topical NSAID is diclofenac. Therefore, the current request cannot be determined as medically appropriate. As such, the request is not medically necessary.

Tramadol 20% cream 30 gm: Upheld

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

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

Decision rationale: California MTUS 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. There is no documentation of a failure to respond to first-line oral medication prior to the initiation of a topical analgesic. There is also no frequency listed in the request. As such, the request is not medically necessary.

Xanax 0.5 #45 (3 refills for 3 month supply): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 24.

Decision rationale: California MTUS Guidelines state benzodiazepines are not recommended for long-term use because long-term efficacy is unproven and there is risk of dependence. There is also no frequency listed in the current request. As such, the request is not medically necessary.

Lidoderm Patch 5% #90: Upheld

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

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

Decision rationale: California MTUS Guidelines state lidocaine is indicated for localized peripheral pain or neuropathic pain after there has been evidence of a trial of first-line therapy with antidepressants and anticonvulsants. There is no documentation of a failure to respond to first-line treatment. There is also no frequency listed in the request. As such, the request is not medically necessary.

Terocin 240ml: Upheld

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

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

Decision rationale: California MTUS 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. There is no documentation of a failure to respond to first-line oral medication prior to the initiation of a topical analgesic. There is also no frequency listed in the request. As such, the request is not medically necessary.

Flurbi (NAP) Cream -La 180grams: Upheld

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

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

Decision rationale: California MTUS Guidelines state topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. The only FDA approved topical NSAID is diclofenac. Therefore, the current request cannot be determined as medically appropriate. As such, the request is not medically necessary.