MAXIMUS Federal Services

Case Number:	CM14-0077763		
Date Assigned:	07/16/2014	Date of Injury:	06/13/2002
Decision Date:	08/29/2014	UR Denial Date:	04/21/2014
Priority:	Standard	Application Received:	05/23/2014

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, 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 66-year-old a female who reported injury on 06/13/2002 due to a slip and fall. The injured worker has diagnoses of C4-5 and C5-6 adjacent segment degeneration, L3-4 adjacent segment degeneration and S1 joint dysfunction. The injured worker's past medical treatment consists of physical therapy, a home exercise program, and medication therapy. Medications include Ultracet tablet 37.5/325, Anaprox DS 550 mg, Lidoderm patch 5%, Prilosec 20 mg, Vicodin 5/500, Robaxin 750 mg, Celebrex 200 mg, Medrol 4 mg, and Soma 350 mg. The duration, frequency, and dosage were not submitted in review. MRI of the lumbar spine dated 09/26/2011 revealed that the L4-5 there was no evidence of lumbar fusion, there was no spinal canal or neural foraminal stenosis. L5-S1 revealed that there was no evidence of spinal fusion. There was no indication of disc herniation but there was mild facet hypertrophy. Urine drug screen collected on 08/14/2012 revealed that the injured worker was within the guidelines of the prescriptions. The injured worker complained of daily continuous low back pain which extended to her upper buttocks that radiated down the posterior aspect of her bilateral thighs to groin. The injured worker rated her pain at a 7/10. The injured worker also complained about continuous and worsening bilateral greater trochanter pain, she rated that pain at a 7/10. She stated that she had frequent numbness in her bilateral legs and feet bilaterally, which varied in intensity. Physical examination dated 03/31/2014 revealed that the injured worker's lumbar spine and lower extremities revealed no gross deformity. There was no appreciable swelling or gross atrophy at the paravertebral muscles. There was no evidence of scoliosis and there was normal lordosis. It was noted that the injured worker had tenderness to palpation at the S1 joint and lumbosacral junction. It was shown that the injured worker had a positive Fortin's, compression, and positive thigh thrust. Reflexes of the knees bilaterally were 2+ and of the ankles were absent. It was noted that there was a negative straight leg raise bilaterally at 90 degrees. Motor strength

revealed a hip flexion of 4+/5 bilaterally, hip abduction of 5/5 bilaterally, knee flexion of 5/5 bilaterally, knee extension of 5/5 bilaterally, ankle dorsiflexion of 4+/5 bilaterally, ankle plantar flexion of 5/5, and extensor hallucis longus of 5/5 bilaterally. The treatment plan for the injured worker is to attend a pain management consultation, consider bilateral S1 joint blocks with radiofrequency and continue medication Lidoderm and Soma. The provider is trying to manage the injured worker's pain levels. The Request for Authorization was submitted on 03/31/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Pain management consult: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Introduction, page 1 Page(s): 1.

Decision rationale: The request for Lidoderm patch 1.5% #30 is not medically necessary. The injured worker complained of daily continuous low back pain which extended to her upper buttocks that radiated down the posterior aspect of her bilateral thighs to groin. The injured worker rated her pain at a 7/10. The injured worker also complained about continuous and worsening bilateral greater trochanter pain, she rated that pain at a 7/10. She stated that she had frequent numbness in her bilateral legs and feet bilaterally, which varied in intensity. The California Medical Treatment Utilization Schedule (MTUS) guidelines state Lidoderm is the brand name for a Lidocaine patch produced by [redacted]. They are largely experimental in use with few randomized controlled trials to determine efficacy or safety. Topical Lidocaine may be recommended for localized peripheral pain after there has been evidence of a trial of first line therapy (tricyclic or SNRI antidepressants or an AED such as gabapentin or Lyrica). No other commercially approved topical formulations of Lidocaine (whether creams, lotions or gels) are indicated for neuropathic pain. According to the MTUS Guidelines, Lidocaine is recommended to patients with a diagnosis of radiculopathy. Although the findings in the report show some evidence of segment degeneration there was no diagnosis of such radiculopathy. The injured worker showed no evidence of having trialed and failed any tricyclic or SNRI antidepressants or an AED such as gabapentin or Lyrica. In addition, the request did not include a frequency or duration. As such, the request for Lidoderm patch 1.5% is not medically necessary.

Bilateral S1 joint blocks with radiofrequency ablation if diagnostic: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300.

Decision rationale: The request for Bilateral S1 joint blocks with radiofrequency ablation if diagnostic is not medically necessary. The injured worker complained of daily continuous low back pain which extended to her upper buttocks that radiated down the posterior aspect of her bilateral thighs to groin. The injured worker rated her pain at a 7/10. The injured worker also complained about continuous and worsening bilateral greater trochanter pain, she rated that pain at a 7/10. She stated that she had frequent numbness in her bilateral legs and feet bilaterally, which varied in intensity. According to the CA MTUS/ACOEM guidelines, there is good quality medical literature demonstrating that radiofrequency neurotomy of facet joint nerves in the cervical spine provides good temporary relief of pain. Similar quality literature does not exist regarding the same procedure in the lumbar region. Lumbar facet neurotomies reportedly produce mixed results. Caution is needed due to scarcity of high quality studies. In the submitted report, there were no diagnostic reviews submitted, concluding that the injured worker had any diagnosis of facet joint pain. There was also a lack of documentation showing how the injured worker responded to past medical treatment, to include physical therapy, her home exercise program, and the use of medications. Furthermore, the submitted request did not specify how many blocks the provider was requesting. Given the above, California MTUS/ACOEM guidelines, the request for bilateral S1 joint blocks with radiofrequency ablation is not medically necessary.

Lidoderm patch 1.5% #30: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Chronic Pain Medical Treatment Guidelines Lidocaine page(s) 57-58,112.

Decision rationale: The request for Lidoderm patch 1.5% #30 is non-certified. The injured worker complained of daily continuous low back pain which extended to her upper buttocks that radiated down the posterior aspect of her bilateral thighs to groin. The injured worker rated her pain at a 7/10. The injured worker also complained about continuous and worsening bilateral greater trochanter pain, she rated that pain at a 7/10. She stated that she had frequent numbness in her bilateral legs and feet bilaterally, which varied in intensity. The California Medical Treatment Utilization Schedule (MTUS) guidelines state Lidoderm is the brand name for a lidocaine patch produced by [redacted]. They are largely experimental in use with few randomized controlled trials to determine efficacy or safety. Topical lidocaine may be recommended for localized peripheral pain after there has been evidence of a trial of first line therapy (tricyclic or SNRI antidepressants or an AED such as gabapentin or Lyrica). No other commercially approved topical formulations of lidocaine (whether creams, lotions or gels) are indicated for neuropathic pain. According to the MTUS Guidelines, lidocaine is recommended to patients with a diagnosis of radiculopathy. Although the findings in the report show some evidence of segment degeneration there was no diagnosis of such radiculopathy. The injured worker showed no evidence of having trialed and failed any tricyclic or SNRI antidepressants or an AED such as gabapentin or Lyrica. In addition, the request did not include a frequency or duration. As such, the request for Lidoderm patch 1.5% is non-certified.

Soma 325mg #90: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Carisprodol (Soma) page(s) 29 Page(s): 29.

Decision rationale: The request for Soma 325 mg #90 is not medically necessary. The injured worker complained of daily continuous low back pain which extended to her upper buttocks that radiated down the posterior aspect of her bilateral thighs to groin. The California Medical Treatment Utilization Schedule (MTUS) guidelines do not recommend Soma. This medication is not indicated for long-term or short term use. Carisoprodol (Soma) is now scheduled in several states but not on a federal level. It has been suggested that the main effect is due to generalized sedation and treatment of anxiety. The guidelines stipulate that Soma not be recommended, and if so, it is suggested that the main use be for sedation and treatment of anxiety. The injured worker had no complaints of anxiety, therefore, Soma is not medically necessary. Given the guidelines above, the request for Soma 325 mg is not medically necessary.