

Case Number:	CM14-0091928		
Date Assigned:	08/04/2014	Date of Injury:	05/01/2010
Decision Date:	09/10/2014	UR Denial Date:	05/19/2014
Priority:	Standard	Application Received:	06/17/2014

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 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 32-year-old female who reported trying to support a heavy falling object on 05/01/2010. On 05/06/2014, her diagnoses included discogenic lumbar condition and depression. Her complaints included low back pain, rated at 7/10 to 8/10 with frequent spasms, numbness and tingling, radiating to her bilateral lower extremities. She also complained of depression due to chronic pain that decreased her functionality. Her medications included Motrin 800 mg, Norco 10/325 mg, Topamax 50 mg, Flexeril 7.5 mg, LidoPro lotion, and Terocin patches. On 05/14/2014, she had a right L-5 transforaminal epidural steroid injection. On 07/16/2014, she reported that the injection had given her 1 month of relief. She also stated that physical therapy relieved her symptoms. An electro diagnostic study of her bilateral lower extremities on 06/27/2012 revealed normal bilateral lower extremities. The rationale for the requested medications was that they helped her to be functional. The rationale for the heating pad noted that heat and cold relieved her pain. There was no rationale submitted for the EMG or NCV. A Request for Authorization dated 05/07/2014 was included with the documentation. However, it did not include a request for the NCV.

IMR ISSUES, DECISIONS AND RATIONALES

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

EMG Bilateral Lower Extremities: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back Chapter - EMG (Electromyography).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 1 Prevention Page(s): 77-89.

Decision rationale: The request for EMG of the bilateral lower extremities is medically not necessary. The California ACOEM guidelines recommend that under the optimal system, a clinician acts as the primary case manager. The clinician provides appropriate medical evaluation and treatment, and adheres to a conservative evidence based treatment approach that limits excessive physical medicine usage and referral. The clinician should judiciously select and refer to specialists who will support functional recovery, as well as provide expert medical recommendations. The submitted documentation stated that his worker had electrodiagnostic studies on 06/27/2012, which showed normal bilateral lower extremities. There was no documentation of exacerbation of any condition regarding the bilateral lower extremities. There was no rationale or justification for repeating the electrodiagnostic studies done previously. Additionally, the request did not specify whether the requested test was to be a needle electromyography or a surface electromyography. Therefore, this request for EMG bilateral lower extremities is not medically necessary.

NCV Bilateral Lower Extremities: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back Chapter - NCV (Nerve Conduction Studies).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 1 Prevention Page(s): 77-89.

Decision rationale: The request for NCV of the bilateral lower extremities is not medically necessary. The California ACOEM guidelines recommend that under the optimal system, a clinician acts as the primary case manager. The clinician provides appropriate medical evaluation and treatment, and adheres to a conservative evidence based treatment approach that limits excessive physical medicine usage and referral. The clinician should judiciously select and refer to specialists who will support functional recovery, as well as provide expert medical recommendations. The submitted documentation stated that his worker had electrodiagnostic studies on 06/27/2012, which showed normal bilateral lower extremities. There was no documentation of exacerbation of any condition regarding the bilateral lower extremities. There was no rationale or justification for repeating the electrodiagnostic studies done previously. Therefore, this request for NCV bilateral lower extremities is not medically necessary.

Heating Pad - Purchase: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 298-301.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 298-300. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back, Lumbar & Thoracic, Heat therapy, Knee & Leg, Durable medical equipment (DME).

Decision rationale: The request for heating pad purchase is medically not medically necessary. Per the California ACOEM Guidelines, local applications of heat or cold at home are as effective as those performed by therapists. The Official Disability Guidelines recommend heat therapy as an option for treating low back pain. However, the Guidelines did go on to state that combining continuous low level heat wrap therapy with exercise during the treatment of acute low back pain significantly improves functional outcomes compared with either intervention alone. Heat therapy has been found to be helpful for pain reduction and return to normal function. In the Official Disability Guidelines, durable medical equipment is recommended generally if there is a medical need, and if the device or system meets Medicare's definition of DME, defined as equipment which can withstand repeated use, for example, could normally be rented and used by successive patients, and is primarily and customarily used to serve a medical purpose. This request for heating pad does not meet the Medicare definition of durable medical equipment. Additionally, the body part to which the heating pad was to have been applied was not specified. Also, the setting/level of heat to be used was not specified, nor was frequency of application. Therefore, this request for heating pad purchase is not medically necessary.

Flexeril 7.5 mg, #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines muscle relaxants, pages 63-66 Page(s): 63-66.

Decision rationale: The request for Flexeril 7.5 mg #60 is not medically necessary. The California MTUS Guidelines recommend that muscle relaxants be used with caution as a second line option for short-term treatment of acute exacerbations in patients with chronic low back pain. In most low back pain cases, they show no benefit over NSAIDs. Decisions are based on evidence-based criteria. Muscle relaxants are supported only for short-term use. Chronic use would not be supported by the guidelines. Flexeril per se is recommended for a short course of therapy. It is a skeletal muscle relaxant and a central nervous system depressant. It is not recommended to be used for longer than 2 to 3 weeks. This worker already has a diagnosis of depression. A central nervous system depressant should be used judiciously in someone diagnosed with depression. The documentation submitted notes that this worker has been taking Flexeril since 01/10/2014, which exceeds the guideline recommendations of 2 to 3 weeks. Additionally, there was no frequency of administration included in the request. Therefore, this request for Flexeril 7.5 mg #60 is not medically necessary.

Terocin Patches, #30: 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, pages 111-113 Page(s): 111-113.

Decision rationale: The request for Terocin patches #30 is not medically necessary. The California MTUS Guidelines refer to topical analgesics as largely experimental, with few randomized control trials to determine efficacy or safety. They are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Many agents are compounded for pain control, including local anesthetics. There is little to no research to support the use of many of these agents. Any compounded product that contains at least 1 drug (or drug class) that is not recommended, is not recommended. Terocin patches contain Menthol 4% and Lidocaine 4%. The only form of FDA approved topical application of Lidocaine, is the 5% transdermal patch for neuropathic pain. This request did not specify the body part or parts to which these patches were to have been applied, or the frequency of application. Therefore, this request for Terocin patches #30 is not medically necessary.

Lido Pro Cream 4 oz: 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, pages 111-113 Page(s): 111-113.

Decision rationale: The request for LidoPro cream 4 ounces is not medically necessary. The California MTUS Guidelines refer to topical analgesics as largely experimental, with few randomized control trials to determine efficacy or safety. They are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Many agents are compounded in combination for pain control, including local anesthetics and Capsaicin. There is little to no research to support the use of many of these agents. Any compounded product that contains at least 1 drug (or drug class) that is not recommended, is not recommended. Capsaicin is generally available in a 0.025% formulation as a treatment for osteoarthritis. There have been no studies of the 0.0325% formulation of Capsaicin in LidoPro cream, and there is no current indication that this increase over a 0.025% formulation would provide any further efficacy. LidoPro cream also contains Lidocaine 4.5%. The only form of FDA approved topical application of Lidocaine, is the 5% transdermal patch for neuropathic pain. Additionally, the body part or parts to which this LidoPro cream was to have been applied was not specified, nor was the frequency of application. Therefore, this request for LidoPro cream, 4 ounces is not medically necessary.

Topomax 50 mg, #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-Epilepsy Drugs.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antiepilepsy drugs (AEDs), pages 16-22 Page(s): 16-22.

Decision rationale: The request for Topamax 50 mg #60 is not medically necessary. The California MTUS Guidelines recommend anticonvulsant medications for neuropathic pain. Most randomized control trials for the use of this class of medication for neuropathic pain have been directed at postherpetic neuralgia and painful polyneuropathy with diabetic polyneuropathy being the most common example. There are few randomized control trials directed at central pain and none for painful radiculopathy. During treatment with antiepileptic medications, there should be documentation of pain relief and improvement in function, as well as documentation of side effects incurred with their use. Topamax has been shown to have variable efficacy, with failure to demonstrate efficacy in neuropathic pain with central etiology. It may be considered for use for neuropathic pain when other anticonvulsants have failed. There is no documentation submitted of a quantified reduction in pain or improvement in functional abilities due to the use of Topamax. There was no documentation submitted of failed trials of other first line anticonvulsant medications. Additionally, the request did not specify frequency of administration. Therefore, this request for Topamax 50 mg #60 is not medically necessary.

Back Brace: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 308.

Decision rationale: The request for a back brace is not medically necessary. California ACOEM guidelines recommend that lumbar support is not recommended for the treatment of low back disorders. They have not been shown to have any lasting benefits beyond the acute phase of symptom relief. The clinical information submitted fails to meet the evidence based guidelines for a back brace. Therefore, this request for a back brace is not medically necessary.