

Case Number:	CM15-0109274		
Date Assigned:	06/15/2015	Date of Injury:	12/22/2003
Decision Date:	07/21/2015	UR Denial Date:	05/08/2015
Priority:	Standard	Application Received:	06/05/2015

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
State(s) of Licensure: California, North Carolina
Certification(s)/Specialty: Family Practice

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 63-year old male, with a reported date of injury of 12/22/2003. The diagnoses include marked low back pain, status post lumbar fusion at L4-5 and L5-S1, status post artificial disc replacement at L3-4, lumbar radiculopathy, and lumbar facet syndrome. Treatments to date have included oral medications, anterior L5-S1 discectomy and instrumented fusion on 08/22/2011, and an interferential (IF) unit. The comprehensive pain management consultation report dated 05/07/2014 indicates that the injured worker complained of low back pain, that was rated 7 out of 10 with medication and 9 out of 10 without medication. The pain radiated to the legs down to the toes with numbness and tingling sensation. The physical examination showed moderate tenderness over the lumbar paravertebral musculature, moderate facet tenderness at L5-S1, positive bilateral sacroiliac tenderness, positive bilateral seated and supine straight leg raise test, and decreased lumbar range of motion. The treatment plan included a spinal cord stimulator trial, continuation of present medications, continued use of IF unit, and urine drug screening. The treating physician requested Cialis 20mg, spinal cord stimulator trial, and Dendracin lotion 120ml.

IMR ISSUES, DECISIONS AND RATIONALES

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

Cialis 20 MG #10: 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).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation American Urological Association Guidelines.

Decision rationale: MTUS does not address this topic. Cialis is a phosphodiesterase inhibitor approved to treat erectile dysfunction and symptoms of benign prostatic hypertrophy. The submitted documentation does not indicate the intended indication for Cialis or identify any symptoms of erectile dysfunction or symptoms of BPH. Therefore, the medical necessity of Cialis is not medically necessary.

Spinal Cord Stimulator Trial: 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).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Spinal cord stimulators Page(s): 105-107.

Decision rationale: CA MTUS states that indications for spinal cord stimulator implantation include evidence of failed back syndrome in applicants who have undergone at least one previously failed spine surgery. The claimant should have exhausted all operative and non-operative options, including time, medications, physical therapy, ESIs, adjuvant medications and opioid medications. In this case, the documentation submitted only notes a failure of surgery and medication. Therefore, the request is not medically necessary at this time.

Dendracin Lotion 120 ML #1: Upheld

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

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

Decision rationale: CA MTUS states that topical analgesics are largely experimental in use with few randomized controlled trials to determine safety or efficacy. They are primarily recommended for neuropathic pain when first-line agents (antidepressants and anticonvulsants) have failed. In this case, there is no evidence of failure of first-line agents. The compound requested contains Capsaicin 0.0375%, which is not recommended by the MTUS. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Therefore, this request is deemed not medically necessary.