

Case Number:	CM15-0181677		
Date Assigned:	09/22/2015	Date of Injury:	05/31/2012
Decision Date:	11/06/2015	UR Denial Date:	08/24/2015
Priority:	Standard	Application Received:	09/15/2015

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
 Certification(s)/Specialty: Physical Medicine & Rehabilitation

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

This 54 year old female sustained an industrial injury on 5-31-12. Documentation indicated that the injured worker was receiving treatment for lumbar spine pain with right leg radiculitis. Previous treatment included physical therapy, aqua therapy and medications. In the only documentation submitted for review, a PR-2 dated 8-17-15, the injured worker complained of low back and sciatica pain that was worsening with cold weather. The injured worker stated that she needed more medications. "They are the only thing that helps". Physical exam was remarkable for lumbar spine with spasms and asymmetric range of motion with a list to the right, limited rotation (40% loss), "limited internal rotation and forward flexion to 13.5" from the floor, "weakness of extensor hallucis longus and diminished sensation to light touch in the L5 and S1 distribution." The physician noted that the injured worker had left leg pain but the electromyography did not correlate with the physical exam. The injured worker had completed physical therapy and pool physical therapy but was still not better. The treatment plan included requesting authorization for physical therapy three times a week for four weeks, pool therapy, lumbar epidural steroid injections and Lidopro cream. On 8-24-15, Utilization Review noncertified a request for Lido Pro cream #1 tube, repeat magnetic resonance imaging lumbar spine and additional physical therapy 3x4 for the lumbar spine.

IMR ISSUES, DECISIONS AND RATIONALES

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

LidoPro cream #1: 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: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Topical Analgesics.

Decision rationale: Based on the 08/17/15 progress report provided by treating physician, the patient presents with low back and sciatic pain to left leg. The request is for Lidopro cream #1. RFA dated 08/17/15 was provided. Patient's diagnosis on 08/17/15 included lumbar spine spasm, S1 radiculitis right leg. The patient has an antalgic gait. Physical examination to the lumbar spine on 08/17/15 revealed spasm to the left paraspinal muscles and limited range of motion. Sensation to light touch diminished at L5 and S1 dermatomes. Treatment to date has included imaging and electrodiagnostic studies, physical therapy, pool therapy, and medications. The patient uses Lidocaine cream. Patient's work status not provided. MTUS, Topical Analgesics Section page 111 states: "Topical Analgesics: Recommended as an option as indicated below. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Topical lidocaine, in the formulation of a dermal patch (Lidoderm) has been designated for orphan status by the FDA for neuropathic pain. Lidoderm is also used off-label for diabetic neuropathy. No other commercially approved topical formulations of lidocaine (whether creams, lotions or gels) are indicated for neuropathic pain." In this case, treater has not provided reason for the request, nor discussed where this topical is applied and with what efficacy. Nonetheless, MTUS page 111 states that if one of the compounded topical product is not recommended, then the entire product is not. In this case, the requested topical compound contains Lidocaine, which is not supported for topical use in lotion form, per MTUS. This request is not in accordance with guideline indications. Therefore, the request is not medically necessary.

Lumbar Spine MRI: Upheld

Claims Administrator guideline: Decision based on MTUS Low Back Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines.

MAXIMUS guideline: Decision based on MTUS Low Back Complaints 2004, Section(s): Special Studies.

Decision rationale: Based on the 08/17/15 progress report provided by treating physician, the patient presents with low back and sciatic pain to left leg. The request is for Lumbar spine MRI. RFA dated 08/17/15 was provided. Patient's diagnosis on 08/17/15 included lumbar spine spasm, S1 radiculitis right leg. The patient has an antalgic gait. Treatment to date has included imaging and electrodiagnostic studies, physical therapy, pool therapy, and medications. The patient uses Lidocaine cream. Patient's work status not provided. ACOEM Guidelines, Low Back Chapter 8, Special Studies, pages 177 and 178, state "Unequivocal objective findings that identify specific

nerve compromise on the neurological examination are sufficient evidence to warrant imaging in patients who do not respond to treatment and who would consider surgery an option". ODG guidelines, Low back chapter under MRI's (magnetic resonance imaging) (L-spine) states that "for uncomplicated back pain MRIs are recommended for radiculopathy following at least one month of conservative treatment." ODG Guidelines do not support MRIs unless there are neurologic signs/symptoms present. "Repeat MRI's are indicated only if there has been progression of neurologic deficit." Physical examination to the lumbar spine on 08/17/15 revealed spasm to the left paraspinal muscles and limited range of motion. Sensation to light touch diminished at L5 and S1 dermatomes. Per 08/17/15 report, treater states "still need auth for repeat L/S MRI to R/O HNP." However, according to guidelines, for an updated or repeat MRI, the patient must be post-operative or present with a new injury, red flags such as infection, tumor, fracture or neurologic progression. This patient does not present with any other condition to warrant another repeat MRI study. This request is not in accordance with guidelines. Therefore, the request is not medically necessary.

12 additional physical therapy visits for the lumbar spine, 3 times 4: Upheld

Claims Administrator guideline: Decision based on MTUS Postsurgical Treatment 2009. Decision based on Non-MTUS Citation Official Disability Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Physical Medicine.

Decision rationale: Based on the 08/17/15 progress report provided by treating physician, the patient presents with low back and sciatic pain to left leg. The request is for 12 additional physical therapy visits for the lumbar spine, 3 times 4. RFA dated 08/17/15 was provided. Patient's diagnosis on 08/17/15 included lumbar spine spasm, S1 radiculitis right leg. The patient has an antalgic gait. Physical examination to the lumbar spine on 08/17/15 revealed spasm to the left paraspinal muscles and limited range of motion. Sensation to light touch diminished at L5 and S1 dermatomes. Treatment to date has included imaging and electrodiagnostic studies, physical therapy, pool therapy, and medications. The patient uses Lidocaine cream. Patient's work status not provided. MTUS Physical Medicine Section, pages 98, 99 has the following: "Physical Medicine: recommended as indicated below. Allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home Physical Medicine". MTUS guidelines pages 98, 99 states that for "Myalgia and myositis, 9-10 visits are recommended over 8 weeks. For Neuralgia, neuritis, and radiculitis, 8-10 visits are recommended." Per 08/17/15 report, treater states "still need auth for PT TIW for 4 weeks and since not better consider epidural - completed PT - No response." In this case, treater has not documented efficacy of prior therapy, not explained why on-going therapy is needed, nor reason patient is unable to transition into a home exercise program. Furthermore, the request for 12 additional sessions would exceed what is allowed by MTUS for the patient's condition. Therefore, the request is not medically necessary.