

Case Number:	CM15-0032507		
Date Assigned:	02/26/2015	Date of Injury:	09/29/1999
Decision Date:	07/01/2015	UR Denial Date:	01/23/2015
Priority:	Standard	Application Received:	02/20/2015

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: New York

Certification(s)/Specialty: Pediatrics, Internal Medicine

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 70-year-old male who sustained an industrial injury on 09/29/99. He reports Low back pain with left lower extremity paresthesia. Diagnoses include post laminectomy lumbar spine, carpal tunnel syndrome, impingement syndrome, mononeuritis multiplex, lumbar radiculopathy, arthritis, and derangement of the knee. Treatments to date include lumbar laminectomy and medications. In a progress note dated 01/104/15 the treating provider recommends an EMG/NCV of the lower extremities, referral to a spine surgeon, MRIs of the cervical and lumbar spine, and treatment with Oxycontin, Terocin patches, and bupropion. On 01/23/15 Utilization Review non-certified the EMG/NCV, spinal surgeon consultation, Oxycontin, and Terocin, citing MTUS guidelines. The bupropion was also non-certified, citing non-MTUS guidelines.

IMR ISSUES, DECISIONS AND RATIONALES

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

EMG/NCV of the bilateral lower extremities: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

Decision rationale: According to MTUS guidelines electromyography (EMG), including H-reflex tests, may be useful to identify subtle, focal neurologic dysfunction in patients with low back symptoms lasting more than three or four weeks. MTUS does not have recommendations regarding NCS. ODG states that EMG is recommended as an option (needle, not surface). EMGs (electromyography) may be useful to obtain unequivocal evidence of radiculopathy, after 1-month conservative therapy, but EMG's are not necessary if radiculopathy is already clinically obvious. ODG states that NCS is not recommended. There is minimal justification for performing nerve conduction studies when a patient is presumed to have symptoms on the basis of radiculopathy. Due to the request, being for both studies and longstanding L5 radiculopathy consistent with prior back pathology and subsequent surgery it is considered not medically reasonable and necessary.

Consult with a spinal surgeon: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints
Page(s): 305-306.

Decision rationale: ACOEM guidelines state that referral for surgical consultation is indicated for patients who have severe and disabling lower leg symptoms in a distribution consistent with abnormalities on imaging studies (radiculopathy), preferably with accompanying objective signs of neural compromise, or activity limitations due to radiating leg pain for more than one month or extreme progression of lower leg symptoms or clear clinical, imaging, and electrophysiologic evidence of a lesion that has been shown to benefit in both the short and long term from surgical repair or a failure of conservative treatment to resolve disabling radicular symptoms. The IW is documented to have a persistent radiculopathy and postlaminectomy syndrome with no progression of symptoms. This request is not medically necessary.

Oxycontin 10 mg #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use; 4) On-Going Management; 6) When to Discontinue Opioids; 7) When to Continue Opioids for chronic pain Page(s): 78-80.

Decision rationale: The IW has been on long term opioids, which is not recommended. Additionally, documentation did not include review and documentation of pain relief, functional status, appropriate medication use, and side effects. Pain assessment should include: current pain; the least reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid; how long it takes for pain relief; and how long pain relief lasts.

Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. This request is not medically necessary and appropriate.

Bupropion tablet 150 mg #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressants for chronic pain Page(s): 13-16. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back - Antidepressants.

Decision rationale: Per ODG guidelines, there are no antidepressant medications that have been shown to be efficacious for treatment of lumbosacral radiculopathy. MTUS guidelines state that antidepressants for chronic pain are recommended as a first line option for neuropathic pain, and as a possibility for non-neuropathic pain. Tricyclics are generally considered a first-line agent unless they are ineffective, poorly tolerated, or contraindicated. Specifically, bupropion (Wellbutrin), a second-generation non-tricyclic antidepressant (a noradrenaline and dopamine reuptake inhibitor) has been shown to be effective in relieving neuropathic pain of different etiologies in a small trial. The documentation provided does not comment on the indication for the Wellbutrin or previous medications tried, without this information we cannot determine that this request is medically necessary.

Terocin patch #30 with 1 refill: 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 Page(s): 111-113.

Decision rationale: MTUS guidelines state that lidocaine is recommended for localized peripheral pain after there has been evidence of a trial of first-line therapy. The documentation in the case file does not indicate that the IW tried any other medications without success. Even though menthol is approved for topical use this cannot be approved due to other components not being medically necessary. This request is not medically appropriate and reasonable.