

Case Number:	CM14-0123566		
Date Assigned:	08/08/2014	Date of Injury:	04/29/2010
Decision Date:	09/29/2014	UR Denial Date:	07/14/2014
Priority:	Standard	Application Received:	08/05/2014

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 Nevada. 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 records, presented for review, indicate that this 40-year-old individual was reportedly injured on April 29, 2010. The mechanism of injury was noted as a pushing type event. The most recent progress note, dated July 25, 2014, indicated that there were ongoing complaints of neck and back pains. The physical examination demonstrated a 4 feet 9 inch, 155 pound individual in mild to moderate distress. A decrease in cervical spine range of motion was noted. Deep tendon reflexes were 2+ equal throughout the bilateral upper extremities. Motor function was 5/5 and grip strength was reported at "0/0/0" on the left. A slight decrease in lumbar spine range of motion was also noted and the right Achilles tendon reflex was 1+. Right lower extremity motor function was 4/5. Sensation was decreased. Diagnostic imaging studies objectified a disc bulge at L5-S1. Previous treatment included epidural steroid injection (August 7, 2014), trigger point injections, chiropractic care (with an associated exacerbation of symptomatology) and multiple medications. A request had been made for multiple medications, a single point cane, electrodiagnostic testing and injection therapy and was not certified in the pre-authorization process on July 14, 2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Norco 10/325mg #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 74-78,88,91.

Decision rationale: Norco (Hydrocodone/Acetaminophen) is a short acting opiate indicated for the management of moderate to severe breakthrough pain. The California MTUS guidelines support short-acting opiates at the lowest possible dose to improve pain and function, as well as the ongoing review and documentation of pain relief, functional status, appropriate medication use and side effects. The injured employee has chronic pain; however, there is no objective clinical documentation of improvement in the pain or function with the current regimen. This is a 4-year-old disc herniation that has undergone local injection therapy and no improvement is noted. As such, this request for Norco is not medically necessary.

Anaprox DS 550mg #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 66 & 73.

Decision rationale: This medication has been recommended as an option for treating low back pain. However, when considering the date of injury, the disc herniation identified, the lack of response to injection therapy or any other intervention, there is no data documenting that this medication has demonstrated any efficacy or utility for the treatment of low back pain. Therefore, based on this lack of improvement, this is not medically necessary.

LidoPro topical analgesic cream 121mg: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 56.

Decision rationale: As outlined in the MTUS guidelines, there is support for the use of topical Lidocaine for individuals with neuropathic pain that have failed treatment with first-line therapy including antidepressants or anti-epileptic medications. Based on the clinical documentation provided, the claimant continues to have low back pain with a modest disc protrusion. There is no objectified efficacy or utility with the application of this topical preparation. As such, the request is considered not medically necessary.

Single point cane: 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)- Treatment for Workers' Compensation (TWC).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG): Low back chapter updated August 2014.

Decision rationale: The ACOEM and MTUS guidelines do not address this topic for low back pain and gait abnormalities. The parameters noted in the ODG were used. This is an individual who is noted to have an unsteady gait, and there is no narrative presented of how a single point cane would be useful in an assistive fashion. Furthermore, there was no comprehensive gait analysis completed, and it is not clear if some other device would be more appropriate to address the specific needs. Therefore, based on the parameters noted in the ODG and by the limited physical examination presented for review, there is no medical necessity established for a single point cane.

Electromyogram (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)- Treatment for Workers' Compensation (TWC) Low Back Chapter.

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

Decision rationale: As outlined in the MTUS, electrodiagnostic studies are recommended where there is unequivocal evidence on CT or MRI and there are ongoing pain complaints that raise a question about whether there is a neurological compromise. The records reflect previous epidural steroid injections and well documented neurological losses. There does not appear to be any subtle neurological dysfunction losses identified. As such, the diagnosis has been established and the appropriate treatment plan outlined. The request for EMG Bilateral Lower Extremities is not medically necessary.

Nerve Conductive Velocity (NVC) 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)- Treatment for Workers' Compensation (TWC) Low Back Chapter.

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

Decision rationale: As outlined in the MTUS, electrodiagnostic studies are recommended where there is unequivocal evidence on CT or MRI and there are ongoing pain complaints that raise a question about whether there is a neurological compromise. The records reflect previous epidural steroid injections and well documented neurological losses. There does not appear to be any subtle neurological dysfunction losses identified. As such, the diagnosis has been

established and the appropriate treatment plan outlined. The request for NVC Bilateral Lower Extremities is not medically necessary.