

Case Number:	CM14-0144691		
Date Assigned:	09/12/2014	Date of Injury:	06/29/2011
Decision Date:	10/14/2014	UR Denial Date:	08/15/2014
Priority:	Standard	Application Received:	09/08/2014

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 & 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:

According to the records made available for review, this is a 65-year-old female with a 6/29/11 date of injury. At the time (8/5/14) of request for authorization for Left Troch Bursa Cortisone Injection under US Guidance, Supplies for TENS unit, MRI (Magnetic Resonance Imaging) of the Lumbar Spine, and Lidoderm Patches 1 patch Q12H on/Q12H off #30, there is documentation of subjective (low back pain radiating down to the heels with numbness, tingling and weakness sensation) and objective (tenderness to palpitation over the lumbar spine muscles, marked tenderness to palpitation over the left trachanteric bursa, positive straight leg raise, decreased sensation over the left L5, numbness of the 4th toe, and 2/5 deep tendon reflexes in the lower extremity bilaterally) findings, (reported MRI of lumbar spine (8/10/12) revealed mild anterolisthesis of L4 and L5 and 2mm disc protrusion L5-S1; report not available for review), current diagnoses (lumbar radiculopathy, lumbar disc disease, lumbar facet arthropathy, and lumbar musculoligamentous sprain/strain), and treatment to date (activity modification, EMES unit used daily which allows patient to use less Endocet, home exercise program, physical therapy, acupuncture, and medications (including ongoing treatment with Lidoderm patches since at least 4/23/14). Medical report identifies a decrease in pain intensity with medications and that surgery for the lumbar spine is considered. Regarding Cortisone Injection, there is no documentation of moderately advanced or severe hip osteoarthritis or cortisone injection used as short-term pain relief. Regarding MRI study, there is no documentation of diagnosis/condition (with supportive subjective/objective findings) for which a repeated study is indicated (to diagnose a suspected fracture or suspected dislocation, to monitor a therapy or treatment which is known to result in a change in imaging findings and imaging of these changes are necessary to determine the efficacy of the therapy or treatment (repeat imaging is not appropriate solely to determine the efficacy of physical therapy or chiropractic treatment), to follow up a surgical

procedure, to diagnose a change in the patient's condition marked by new or altered physical findings). Regarding Lidoderm Patches, there is no documentation that a trial of first-line therapy (Tri-Cyclic or SNRI Anti-Depressants or an AED such as Gabapentin or Lyrica) has failed, and functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications as a result of Lidoderm patch use to date.

IMR ISSUES, DECISIONS AND RATIONALES

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

Left Troch Bursa Cortisone Injection Under US Guidance: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines-Hip Chapter

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Hip & Pelvis, Intra-articular steroid hip injection (IASHI)

Decision rationale: MTUS does not address the issue. ODG identifies documentation of moderately advanced or severe hip osteoarthritis or as short-term pain relief in hip trochanteric bursitis, as criteria necessary to support the medical necessity of intra-articular steroid hip injection. In addition, ODG additionally identifies that injection should be used in conjunction with fluoroscopic guidance. Within the medical information available for review, there is documentation of diagnoses of lumbar radiculopathy, lumbar disc disease, lumbar facet arthropathy, and lumbar musculoligamentous sprain/strain. However, there is no documentation of moderately advanced or severe hip osteoarthritis or cortisone injection used as short-term pain relief. Therefore, based on guidelines and a review of the evidence, the request for Left Troch Bursa Cortisone Injection under US Guidance is not medically necessary.

Supplies for TENS Unit: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300, Chronic Pain Treatment Guidelines Transcutaneous Electrical Nerve Stimulation (TENS), and Interferential Current Stimulation (ICS).

Decision rationale: MTUS reference to ACOEM identifies that physical modalities, such as transcutaneous electrical neurostimulation (tens) units, have no scientifically proven efficacy in treating acute low back symptoms. MTUS chronic pain medical treatment guidelines identifies that interferential current stimulation (ICS), microcurrent electrical stimulation (MENS devices), and neuromuscular electrical stimulation (NMES devices) are not recommended. Within the medical information available for review, there is documentation of diagnoses of lumbar radiculopathy, lumbar disc disease, lumbar facet arthropathy, and lumbar musculoligamentous sprain/strain. In addition, there is documentation of ongoing treatment with EMES unit daily,

which allows patient to use less Endocet. However, despite documentation of a request for supplies for TENS unit, there is documentation of ongoing treatment with EMES unit (that is not recommended). Therefore, based on guidelines and a review of the evidence, the request for Supplies for TENS unit is not medically necessary.

MRI (Magnetic Resonance Imaging) of the Lumbar Spine: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-304. Decision based on Non-MTUS Citation MTUS Official Disability Guidelines (ODG), Parameters for Medical Imaging

Decision rationale: MTUS reference to ACOEM guidelines identifies documentation of red flag diagnoses where plain film radiographs are negative; objective findings that identify specific nerve compromise on the neurologic examination, failure of conservative treatment, and who are considered for surgery, as criteria necessary to support the medical necessity of MRI. ODG identifies documentation of a diagnosis/condition (with supportive subjective/objective findings) for which a repeat study is indicated (such as: To diagnose a suspected fracture or suspected dislocation, to monitor a therapy or treatment which is known to result in a change in imaging findings and imaging of these changes are necessary to determine the efficacy of the therapy or treatment (repeat imaging is not appropriate solely to determine the efficacy of physical therapy or chiropractic treatment), to follow up a surgical procedure, to diagnose a change in the patient's condition marked by new or altered physical findings) as criteria necessary to support the medical necessity of a repeat MRI. Within the medical information available for review, there is documentation of diagnoses of lumbar radiculopathy, lumbar disc disease, lumbar facet arthropathy, and lumbar musculoligamentous sprain/strain. In addition, there is documentation of a 2012 MRI of lumbar spine identifying mild anterolisthesis of L4 and L5 and 2mm disc protrusion L5-S1. However, despite documentation that surgery for the lumbar spine is considered, and given no documentation of a pending surgery that has been authorized/certified, there is no documentation of diagnosis/condition (with supportive subjective/objective findings) for which a repeated study is indicated (to diagnose a suspected fracture or suspected dislocation, to monitor a therapy or treatment which is known to result in a change in imaging findings and imaging of these changes are necessary to determine the efficacy of the therapy or treatment (repeat imaging is not appropriate solely to determine the efficacy of physical therapy or chiropractic treatment), to follow up a surgical procedure, to diagnose a change in the patient's condition marked by new or altered physical findings). Therefore, based on guidelines and a review of the evidence, the request for MRI (Magnetic Resonance Imaging) of the Lumbar Spine is not medically necessary.

Lidoderm Patches 1 patch Q12H on/Q12H off #30: 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 Lidoderm (Lidocaine patch) Page(s): 56-57. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines identifies documentation of neuropathic pain after there has been evidence that a trial of first-line therapy (tri-cyclic or SNRI anti-depressants or an AED such as Gabapentin or Lyrica) has failed, as criteria necessary to support the medical necessity of a Lidocaine patch. MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. Within the medical information available for review, there is documentation of diagnoses of lumbar radiculopathy, lumbar disc disease, lumbar facet arthropathy, and lumbar musculoligamentous sprain/strain. In addition, there is documentation of neuropathic pain and ongoing treatment with Lidoderm patches. However, there is no documentation that a trial of first-line therapy (Tri-Cyclic or SNRI Anti-Depressants or an AED such as gabapentin or Lyrica) has failed. In addition, despite documentation of decreased pain intensity with medications, there is no documentation of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications because of Lidoderm patch use to date. Therefore, based on guidelines and a review of the evidence, the request for Lidoderm Patches 1 patch Q12H on/Q12H off #30 is not recommended.