MAXIMUS Federal Services

Case Number:	CM14-0160550		
Date Assigned:	10/06/2014	Date of Injury:	10/28/2010
Decision Date:	10/30/2014	UR Denial Date:	09/25/2014
Priority:	Standard	Application Received:	09/30/2014

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 Anesthesiology, has a subspecialty in Pain Management 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 47-year-old male with a 10/28/10 date of injury. At the time (9/15/14) of request for authorization for lumbar spine MRI, lumbar surgical consult, and Voltaren XR 100mg, #30-prescribed 9/15/14, there is documentation of subjective (chronic low back pain radiating to the right leg with numbness and weakness) and objective (decreased strength in the right quad and hip flexors, tenderness to palpation over the lumbar paraspinals, limited lumbar range of motion, and positive straight leg raise on the right) findings, imaging findings (MRI of the lumbar spine (3/1/13) report revealed disc bulge at L3-4 with left lateral recess and foraminal stenosis; degenerative disc disease at L4-5 and L5-S1; and mild bilateral foraminal stenosis at L4-5), electrodiagnostic studies (EMG/NCV of the bilateral lower extremities (9/15/14) revealed normal studies with no evidence of lumbosacral radiculopathy), current diagnoses (chronic pain syndrome and low back pain), and treatment to date (medications (including ibuprofen and omeprazole) and physical therapy). Medical report identifies a request for an updated lumbar MRI, surgical consult pending MRI results, and start Voltaren therapy due to GERD related to ongoing ibuprofen therapy. In addition, 6/20/14 medical report (Orthopedic/Spine Surgery consultation) identifies that the patient is not a surgical candidate as the back pain could be related to degenerative discs seen on MRI. Regarding lumbar spine MRI, there is no documentation of a diagnosis/condition (with supportive subjective/objective findings) for which a repeat study is indicated (to diagnose a change in the patient's condition marked by new or altered physical findings). Regarding lumbar surgical consult, there is no documentation of clear clinical, imaging, and electrophysiologic evidence of a lesion that has been shown to benefit in both the short and long-term from surgical repairRegarding Voltaren XR 100mg, #30-prescribed 9/15/14, there is no documentation of the medical necessity for Voltaren due to increased risk profile.

IMR ISSUES, DECISIONS AND RATIONALES

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

LUMBAR SPINE MRI: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-304.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-304. Decision based on Non-MTUS Citation Other Medical Treatment Guidelines: Official Disability Guidelines (ODG) Minnesota Rules, 5221.6100 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 chronic pain syndrome and low back pain. In addition, there is documentation of a previous lumbar MRI performed on 3/1/13. However, despite documentation of subjective (chronic low back pain radiating to the right leg with numbness and weakness) and objective (decreased strength in the right quad and hip flexors, tenderness to palpation over the lumbar paraspinals, limited lumbar range of motion, and positive straight leg raise on the right) findings, and a request for an updated lumbar MRI to be performed before surgical consult, there is no documentation of a diagnosis/condition (with supportive subjective/objective findings) for which a repeat study is indicated (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 lumbar spine MRI is not medically necessary.

LUMBAR SURGICAL CONSULT: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Page(s): 127.

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

Decision rationale: MTUS reference to ACOEM Guidelines identifies documentation of severe and disabling lower leg symptoms in the distribution consistent with abnormalities on imaging

studies (radiculopathy), preferably with accompanying objective signs of neural compromise; Activity limitations due to radiating leg pain for more than one month or extreme progression of lower leg symptoms; 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; and failure of conservative treatment to resolve disabling radicular symptoms, as criteria necessary to support the medical necessity of a spine specialist referral. Within the medical information available for review, there is documentation of diagnoses of chronic pain syndrome and low back pain. In addition, there is documentation of a request for lumbar surgical consult pending MRI results. However, despite documentation of subjective (chronic low back pain radiating to the right leg with numbness and weakness) and objective (decreased strength in the right quad and hip flexors, tenderness to palpation over the lumbar paraspinals, limited lumbar range of motion, and positive straight leg raise on the right) findings, and given documentation of a recent surgical consultation identifying that the patient is not a surgical candidate; normal electrodiagnostic studies; and non-certification of an associated request for lumbar MRI, there is no documentation of 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. Therefore, based on guidelines and a review of the evidence, the request for Orthopedic surgeon spine consultation for the low back is not medically necessary.

VOLTAREN XR 100MG, #30-PRESCRIBED 9/15/14: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs (non-steroidal anti-inflammatory drugs) Page(s): 67-68. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Diclofenac sodium (Voltaren, Voltaren-XR) Other Medical Treatment Guideline or Medical Evidence: Title 8, California Code of Regulations, section 9792.20

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines identifies documentation of moderate to severe osteoarthritis pain, acute low back pain, chronic low back pain, or exacerbations of chronic pain, as criteria necessary to support the medical necessity of NSAIDs. 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. ODG identifies that Voltaren is not used as first line therapy due to increased risk profile. Within the medical information available for review, there is documentation of diagnoses of chronic pain syndrome and low back pain. In addition, there is documentation of chronic low back pain and a request to start Voltaren therapy due to GERD related to ongoing ibuprofen therapy. However, despite documentation of Voltaren used as second line therapy, and given documentation of GERD related to chronic NSAID use, there is no documentation of the medical necessity for Voltaren due to increased risk profile. Therefore, based on guidelines and a review of the evidence, the request for Voltaren XR 100mg, #30-prescribed 9/15/14 is not medically necessary.