

Case Number:	CM14-0176179		
Date Assigned:	10/29/2014	Date of Injury:	05/04/2010
Decision Date:	05/01/2015	UR Denial Date:	09/29/2014
Priority:	Standard	Application Received:	10/23/2014

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. 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 Jersey, Michigan, California
 Certification(s)/Specialty: Neurology, Neuromuscular 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 43 year old female, who sustained an industrial injury on 5/4/10. The injured worker was diagnosed as having multilevel lumbar disc herniation and stenosis status post posterior fusion and anterior fusion, left lower extremity radicular pain with S1 radiculopathy and weakness, chronic left ankle sprain, chronic cervical sprain and urinary and fecal incontinence. Treatment to date has included aquatic therapy, acupuncture, oral medications including Tylenol #3 and activity restrictions. Currently, the injured worker complains of low back and left ankle pain which are constant. The injured worker is currently taking Tylenol #3 also Prilosec and Robaxin, which she states are not helping her. Physical exam noted limited range of motion of lumbar spine with tenderness to the paraspinals equally and normal range of motion of the left ankle. The treatment plan for the only progress note included is to continue medications, appointments for aquatic therapy and acupuncture and consultation for sleep study for cervical spine pain.

IMR ISSUES, DECISIONS AND RATIONALES

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

Lidoderm patches 5% #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111.

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

Decision rationale: According to MTUS guidelines, "Lidoderm is the brand name for a lidocaine patch produced by Endo Pharmaceuticals. Topical lidocaine may be recommended for localized peripheral pain after there has been evidence of a trial of first-line therapy (tri-cyclic or SNRI anti-depressants or an AED such as gabapentin". In this case, there is no documentation that the patient developed neuropathic pain that did not respond to first line therapy and the need for Lidoderm patch is unclear. There is no documentation of efficacy of previous use of Lidoderm patch. Therefore, the prescription of Lidoderm patches #60 is not medically necessary.

Follow-up with [REDACTED]: 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 Chronic pain programs, early intervention Page(s): 32-33.

Decision rationale: According to MTUS guidelines, the presence of red flags may indicate the need for specialty consultation. In addition, the requesting physician should provide a documentation supporting the medical necessity for a pain management evaluation with a specialist. The documentation should include the reasons, the specific goals and end point for using the expertise of a specialist. In this case, there is no clear documentation for the rational for the request for a follow-up visit. The requesting physician did not provide a documentation supporting the medical necessity for this visit. The provider did not indicate why he feels that the hardware requires to be removed. The provider documentation should include the reasons, the specific goals and end point for the visit. Therefore, the request for follow-up visit is not medically necessary.

Patches and batteries for a TENS unit: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 116.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Guidelines Transcutaneous electrotherapy Page(s): 114.

Decision rationale: According to MUTUS guidelines, TENS is not recommended as primary treatment modality, but a one month based trial may be considered, if used as an adjunct to a functional restoration program. There is no evidence that a functional restoration program is planned for this patient. Furthermore, there is no clear information about the number of hours

that the patient is using TENS unit and the functional improvement. Therefore, the request for Patches and batteries for a TENS unit is not medically necessary.