

Case Number:	CM14-0071853		
Date Assigned:	07/16/2014	Date of Injury:	04/17/2006
Decision Date:	06/02/2015	UR Denial Date:	04/23/2014
Priority:	Standard	Application Received:	05/19/2014

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 York

Certification(s)/Specialty: Emergency 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 60 year old male who sustained an industrial injury on April 17, 2006. The injured worker has been treated for back, chest and left upper extremity complaints. The diagnoses have included brachial neuritis or radiculitis not otherwise specified, thoracic or lumbosacral neuritis unspecified, cervical degenerative disc disease, bilateral carpal tunnel syndrome, cervical radiculopathy, lumbar degenerative disc disease, lumbar radiculopathy, myalgia and myositis and major depressive disorder. Treatment to date has included medications, physical therapy and left shoulder surgery. Current documentation dated April 21, 2014 notes that the injured worker reported back and neck pain. Physical examination revealed the injured worker had a stooped posture and markedly antalgic gait. Examination of the lumbar spine revealed tenderness over the paraspinous muscles bilaterally and a positive straight leg raise test bilaterally. Range of motion was noted to be painful. The treating physician's plan of care included a request for an MRI of the lumbar spine and the medications Norco, Soma and Lidoderm patches. On April 23, 2014, Utilization Review modified request for Norco and Soma. A request for Oxycontin was certified. A request for a lumbar spine MRI and Lidoderm patches were non-certified. CA MTUS and ODG guidelines were cited in support of these decisions.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI of the lumbar spine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back - Lumbar & Thoracic (Acute & Chronic) Indications for imaging - Magnetic resonance imaging.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-304. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back - Magnetic resonance imaging.

Decision rationale: CA MTUS ACOEM guidelines recommends magnetic imaging studies for cases "in which surgery is considered or red-flag diagnoses are being evaluated." ODG guidelines state "repeat MRI is not routinely recommended and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology." Documentation does not support significant changes in subjective complaints of objective findings. There is not documentation of new injuries or adjustments to analgesic medication. The IW previous had a lumbar MRI. There is no mention of surgeon evaluation or treatment. There is no documented evidence of new or progression of neurological findings. Therefore, the request for lumbar MRI is not medically necessary.

Lidoderm 5% (700mg/patch) #30 with 2 refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Lidoderm (Lidocaine patch). Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain (Chronic): Criteria for use of Lidoderm patches.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Lidoderm patch Page(s): 56-57.

Decision rationale: CA MTUS is recommended for localized peripheral pain after there has been evidence of a trial of first line therapy such as a tricyclic, serotonin-norepinephrine reuptake inhibitor, or gabapentin. This medication is "not a first-line treatment and is only FDA approved for post-herpetic neuralgia. Further research is needed to recommend this treatment for chronic neuropathic pain disorders other than post-herpetic neuralgia." Ongoing use of this medication requires improvement in pain or function. The IW has been using this treatment for greater the a year. Documentation reports increased pain and no decrease in use of other treatments. Based on lack of improvement with this medication, the request for lidoderm patches is not medically necessary.

Norco 10/325mg #150 with 2 refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids
Page(s): 77-81.

Decision rationale: CA MTUS, chronic pain guidelines, offer very specific guidelines for the ongoing use of narcotic pain medication to treat chronic pain. These recommendations state that the lowest possible dose be used as well as ongoing review and documentation of pain relief, functional status, appropriate medication use and its side effects. It also recommends that providers of opiate medication document the injured worker's response to pain medication including the duration of symptomatic relief, functional improvements, and the level of pain relief with the medications. Guidelines also recommend random drug screening. The included documentation fails to include the above recommended documentation. The IW has been using opiate narcotics for several years. The IW has not demonstrated improvement in function and reports increased pain despite use of opiates. Urine drug screens included in the documentation provide results inconsistent with the IW prescribed medications. There is no discussion in the records of these results. Finally, the request does not include dosing frequency or duration. The request for opiate analgesia is not medically necessary.

Soma 350mg #60 with 2 refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Carisoprodol (Soma).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Carisoprodol Page(s): 29.

Decision rationale: According to CAMTUS, Carisoprodol (Soma) is not recommended. Additionally, it is not recommended for long term use. Medical records support the IW has been taking this medication for a minimum of 12 months. In addition, dosing and frequency is not included in the request. As this medication is not supported by guidelines, the request for Soma is determined not medically necessary.