

Case Number:	CM15-0093357		
Date Assigned:	05/19/2015	Date of Injury:	07/26/2014
Decision Date:	06/19/2015	UR Denial Date:	04/14/2015
Priority:	Standard	Application Received:	05/14/2015

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: Neurological Surgery

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 58 year old female with an industrial injury dated 7/26/2014. The injured worker's diagnoses include coccyx trauma, L5-S1 traumatic spondylolisthesis and head trauma. Treatment consisted of diagnostic studies, prescribed medications, and periodic follow up visits. In a progress note dated 4/1/2015, the injured worker reported occasional headaches, occasional nausea, frequent pain in the right hand, back pain, bladder and bowel dysfunction, bilateral hip pain, pain in the left foot and occasional pain in the right side. Objective findings revealed tenderness and hypertonicity of the lumbar paraspinal and quadratus lumborum. Positive straight leg raise test on the left and decrease sensation in the L5 and S1 distribution were also noted on exam. Documentation states X-ray of the lumbar spine dated 4/1/2015 revealed spondylolisthesis at L5-S1 with widening of disc space and evidence of instability, however, no radiologic report is found to support this statement. Prior studies did not state such spondylolisthesis existed. Treatment plan consisted of diagnostic workup due to continued low back pain with numbness in the leg and medication management for chronic muscular pain and inflammation. The treating physician prescribed services for Keratek gel 4oz bottle, Ultram (quantity unspecified), Naproxyn (quantity unspecified), Electromyography (EMG) /Nerve conduction velocity (NCV) and spine surgeon consult now under review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Keratek gel 4oz bottle: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical analgesics. Decision based on Non-MTUS Citation Official Disability Guidelines, Pain Chapter Topical analgesics.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical analgesics Page(s): 111.

Decision rationale: California MTUS guidelines do recommend topical analgesics as an option when a trial of antidepressants has failed. Documentation does not show such a failed trial. The guidelines also recommend topical analgesics as an option if a trial of anticonvulsants has failed. Documentation does not show evidence of such failure. The guidelines also note the provider should have knowledge of the specific analgesic effect of the compounded medication. Documentation does not provide this evidence. The requested treatment: Keratek gel 4oz bottle Is NOT Medically necessary and appropriate.

Ultram (quantity unspecified): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Tramadol (Ultram) Page(s): 113, 93-4.

Decision rationale: The California MTUS Chronic Pain Medical Treatment guidelines note Tramadol is not recommended as a first-line oral analgesic. They note the side effects of dizziness, nausea, constipation, headache, somnolence and increased risk of seizures is the patient is taking SSRIs and other opioids. Documentation does not provide evidence the patient is not having side effects. They note the recommended dose should not exceed 400mg/day. This request does not specify the quantity. The requested treatment: Ultram (quantity unspecified) is NOT medically necessary and appropriate.

Naproxyn (quantity unspecified): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Nonsteroidal anti-inflammatory drug.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS-Naproxen Page(s): 73.

Decision rationale: The California Chronic Pain Medical Treatment Guidelines recommend Naproxen up to 1500/day for limited periods not to exceed 1650 mg. This request does not include a quantity. The requested treatment: Naproxyn (quantity unspecified) is NOT medically necessary and appropriate.

EMG/NCV: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303, Chronic Pain Treatment Guidelines Official Disability Guidelines, Low Back Page(s): 62.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303.

Decision rationale: The California MTUS guidelines note that electromyography (EMG) may be useful to identify subtle, focal neurologic dysfunction. The documentation shows EMG was accomplished on 3/12/15. Documentation does not contain rationale as to why it should be repeated. The requested treatment: EMG/NCV is NOT medically necessary and appropriate.

Spine surgeon consult: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM guidelines, page 127.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-307.

Decision rationale: The California MTUS guidelines recommend surgical considerations when the patient has had severe persistent, debilitating lower extremity complaints referable to a specific nerve root or spinal cord level corroborated by clear imaging, clinical examination and electrophysiological studies. Documentation does not show this evidence. Prior MRI scans of lumbar spine show no disc herniation. The guidelines note the patient would have failed a trial of conservative therapy. Documentation does not show such failure. The guidelines note the surgical repair proposed for the lesion must have evidence of efficacy both in the short and long term. The requested treatment: Spine surgeon consult is NOT medically necessary and appropriate.