

Case Number:	CM15-0095927		
Date Assigned:	05/22/2015	Date of Injury:	09/08/2008
Decision Date:	06/30/2015	UR Denial Date:	04/29/2015
Priority:	Standard	Application Received:	05/18/2015

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: Anesthesiology

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 56 year old male who sustained a work related injury September 8, 2008. He experienced a fall injuring resulting in pain, numbness and weakness at the lower back, left hip and knee. Past history included s/p lumbar decompression and fusion August 2012, L5-S1 anterior lumbar interbody fusion, removal of cage L5-S1 anterior instrumentation, March 2014, s/p bowel resection (small bowel necrosis/superior mesenteric artery thrombosis) hypertension, and diabetes. A primary treating physician evaluated the injured worker March 15, 2015 for depression and recommended continued psychotherapy, biofeedback and medication. According to a request for authorization form, dated April 22, 2015, diagnoses are documented as lumbar facet pain and sacroiliac joint pain. At issue, is the request for authorization for transdermal creams, Lidoderm patches, MRI left hip, x-ray lumbar, electrodiagnostic studies, and hematologist or urologist consultation.

IMR ISSUES, DECISIONS AND RATIONALES

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

Transdermal creams 20% 30gms: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical analgesics Page(s): 111-113.

Decision rationale: According to the California MTUS Guidelines (2009), topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. These agents are applied topically to painful areas with advantages that include lack of systemic side effects, absence of drug interactions, and no need to titrate. Many agents are compounded as monotherapy or in combination for pain control including, for example, NSAIDs, opioids, capsaicin, muscle relaxants, local anesthetics or antidepressants. Guidelines indicate that any compounded product that contains at least 1 non-recommended drug (or drug class) is not recommended for use. MTUS guidelines state that Flurbiprofen, lidocaine, capsaicin and/or muscle relaxants are not recommended for topical applications. In this case, there is no documentation of intolerance to other previous oral medications. It is also unclear as to what the exact ingredients are in the requested transdermal cream. There is no rationale provided for the use of topical cream. Medical necessity for the requested transdermal cream has not been established. The requested item is not medically necessary.

Lidoderm patches 5% #30: Upheld

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

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

Decision rationale: According to the California MTUS Guidelines (2009), topical analgesics, such as the Lidoderm 5% patch, are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. These agents are applied topically to painful areas with advantages that include lack of systemic side effects, absence of drug interactions, and no need to titrate. Many agents are compounded as monotherapy or in combination for pain control, for example, NSAIDs, opioids, or antidepressants. Lidoderm is the brand name for a lidocaine patch. 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 or Lyrica). Lidoderm patches are not a first-line treatment and are 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. In this case, medical necessity of the requested item has not been established. The certification of the requested Lidoderm patches are not medically necessary.

EMG bilateral Lower extremities: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 287-316.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 177-179. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Nerve Conduction Velocity Testing.

Decision rationale: There is no documentation provided necessitating EMG testing of both lower extremities. According to the ODG, EMG (Electromyography) and nerve conduction studies are an extension of the physical examination. They can be useful in adding in the diagnosis of peripheral nerve and muscle problems. This can include neuropathies, entrapment neuropathies, radiculopathies, and muscle disorders. According to ACOEM Guidelines, needle EMG and H-reflex tests to clarify nerve root dysfunction are recommended for the treatment of low back disorders. The patient has mostly described axial lower back pain. Physical examination does not identify motor or sensory deficits that would suggest the presence of radiculopathy or other neuropathy. In the absence of neurological deficits, electrodiagnostic testing is not medically appropriate. Medical necessity for the requested item has not been established, as guideline criteria have not been met. The requested EMG is not medically necessary.

NCV bilateral lower extremities: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 287-316.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 177-179. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Nerve Conduction Velocity Testing.

Decision rationale: (Electromyography) and nerve conduction studies are an extension of the physical examination. They can be useful in adding in the diagnosis of peripheral nerve and muscle problems. This can include neuropathies, entrapment neuropathies, radiculopathies, and muscle disorders. According to ACOEM Guidelines, needle EMG and H-reflex tests to clarify nerve root dysfunction are recommended for the treatment of low back disorders. The patient has mostly described axial lower back pain. Physical examination does not identify motor or sensory deficits that would suggest the presence of radiculopathy or other neuropathy. In the absence of neurological deficits, electro diagnostic testing is not medically appropriate. Medical necessity for the requested item has not been established, as guideline criteria have not been met. The requested EMG is not medically necessary.

Hematologist or Urologist Consult: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Chapter 7 page 127-146.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment.

Decision rationale: According to the CA MTUS/ACOEM, a consultation is indicated to aid in the diagnosis, prognosis, and therapeutic management, determination of medical stability, and permanent residual loss and/or, the injured worker's fitness to return to work. The medical records do not clarify a clinical rationale for a hematology and/or urology consult. According to the medical records, the patient requires a hematological and urological consult for urological issues. However, there is no clarification or rationale regarding what specific issues the patient has. There are no subjective complaints or objective findings that would support the need for a specialty evaluation. Medical necessity for the requested service is not established. The requested Hematology or Urology consult is not medically necessary.

MRI left hip: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Hip and Pelvis; MRI.

Decision rationale: According to the ODG, MRI is the most accepted form of imaging for finding avascular necrosis of the hip and osteonecrosis. MRI is both highly sensitive and specific for the detection of many abnormalities involving the hip or surrounding soft tissues and should in general be the first imaging technique employed following plain films. MRI seems to be the modality of choice for the next step after plain radiographs in evaluation of select patients with an occult hip fracture in whom plain radiographs are negative and suspicion is high for occult fracture. This imaging is highly sensitive and specific for hip fractures. Even if a fracture is not revealed, other pathology responsible for the patient's symptoms may be detected, which will direct treatment plans. Indications for imaging include, osseous, articular or soft-tissue abnormalities, osteonecrosis, occult acute and stress fractures, acute and chronic soft-tissue injuries, and tumors. This patient previously underwent a left hip MRI in May 2012. Since that time, there has been no evidence of progressive functional decline. According to the ODG, a repeat MRI is not routinely recommended and should be reserved for a significant change in symptoms and/or findings. The medical necessity has not been established. Therefore, the request for an MRI of the left hip is not medically necessary.

X ray lumbar flexion/extension: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low back; Radiography (x-rays).

Decision rationale: Lumbar spine radiography should not be recommended in patients with low back pain in the absence of red flags for serious spinal pathology, even if the pain has persisted

for at least 6 weeks. Indiscriminant imaging may result in false positive findings that are not the source of painful symptoms and do not warrant surgery. Imaging is indicated only if patients have severe progressive neurologic impairments or signs or symptoms indicating a serious or specific underlying condition, or if they are candidates for invasive interventions. Immediate imaging is recommended for patients with major risk factors for cancer, spinal infection, cauda equina syndrome, or severe or progressive neurologic deficits. Imaging after a trial of treatment is recommended for patients who have minor risk factors for cancer, inflammatory back disease, vertebral compression fracture, radiculopathy, or symptomatic spinal stenosis. Subsequent imaging should be based on new symptoms or changes in current symptoms. The patient is status post lumbar decompression with fusion in August 2012. There was no evidence of functional or neurological decline postoperatively. There is no evidence of a new injury or functional/neurological decline to support the need for updated imaging to include flexion/extension x-rays. There is also no evidence that the patient is being considered for additional lumbar spine surgery for which dynamic x-rays would be indicated. The medical necessity has not been established. Therefore, the request for a lumbar flexion/extension x-ray is not medically necessary.