

<b>Case Number:</b>	CM13-0010484		
<b>Date Assigned:</b>	09/20/2013	<b>Date of Injury:</b>	04/20/2008
<b>Decision Date:</b>	02/19/2014	<b>UR Denial Date:</b>	07/17/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/14/2013

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Occupational Medicine 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 physician 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:

As noted in the MTUS-Adopted ACOEM Guidelines in Chapter 12, lumbar supports are not recommended outside of the acute phase of symptoms relief. In this case, the applicant's date of injury is April 20, 2008. She is several years removed of the date of injury. She is outside of the acute phase of symptom relief. Continued usage of lumbar support is not indicated. It is further noted that the applicant has used this lumbar support in the past and, as with the many other medications and treatments, has failed to effect any lasting benefit or functional improvement through prior usage of the same. The fact that the applicant remains off of work, on total temporary disability, and remains reliant on various medications, surgeries, etc., imply that previous usage of lumbar support was in fact unsuccessful. Accordingly, the request is not certified.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Bottle of Theramine #60 before 6/3/2013 and 8/22/2013: Upheld**

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Chronic Pain.

**Decision rationale:** The MTUS does not address the topic. As noted in the ODG Chronic Pain Chapter Theramine topic, Theramine, a medical food is not recommended for the treatment of chronic pain, acute pain, neuropathic pain, or fibromyalgia. Therefore, the request is not certified owing to the unfavorable guideline.

**request for Home Health Aide 8hours a day 7days a week between between 6/3/2013 and 8/22/2013:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 51.

**Decision rationale:** The attending provider did not clearly detail or specify what home health services he intended for the applicant to receive. As noted on Page 51 of the MTUS Chronic Medical Treatment Guidelines, Home Health Services are recommended to deliver medically necessary treatment for those individuals, who are home-bound. Home health services for the purposes of facilitating performance of non work activities of daily living are specifically not covered, per page 51 of the MTUS Chronic Medical Treatment Guidelines. In this case, again, the attending provider did not clearly detail or specify what home health services he was seeking here. Therefore, the request is not certified

**90 Nabumetone 750mg between 6/3/2013 and 8/22/2013:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 22.

**Decision rationale:** While page 22 of the MTUS Chronic Medical Treatment Guidelines does endorse usage of NSAIDs such as Relafen or nabumetone as a first line treatment for various chronic pain conditions, including chronic low back pain, in this case, however, the applicant has failed to effect any lasting benefit or functional improvement through prior usage of Relafen. The applicant has failed to return to work. The applicant's complaints of pain are heightened. The applicant's concurrent usage of multiple analgesic medications and pursuit of various surgical remedies, taken together, implies a lack of reduction in dependence on continued medical treatment. Therefore, the request is not certified owing to lack of functional improvement as defined in MTUS 9792.20f.

**90 Cyclobenzaprine 7.5mg between 6/3/2013 and 8/22/2013:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 41.

**Decision rationale:** As noted on page 41 of the MTUS Chronic Medical Treatment Guidelines, addition of cyclobenzaprine or Flexeril to other agents is not recommended. In this case, the applicant is using numerous other analgesic and adjuvant medications. Adding cyclobenzaprine or Flexeril to the mix is not recommended. Therefore, the request is not certified.

**1 single point cane between 6/3/2013 and 8/22/2013: Overturned**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation the Official Disability Guidelines (ODG), Knee.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Knee.

**Decision rationale:** The attending provider has suggested that the claimant is having issues with ambulation. The MTUS does not address the topic of canes. As noted in the ODG knee chapter walking topic, canes and other walking aids are recommended to reduce impairment associated with knee issues. In this case, the applicant has multiple foci of pain with associated gait derangement. Using a cane is appropriate to ameliorate the same. Therefore, the request is certified

**30 Omeprazole DR 20mg between 6/3/2013 and 8/22/2013: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 69.

**Decision rationale:** As noted on page 69 of the MTUS Chronic Medical Treatment Guidelines, proton pump inhibitors such as omeprazole are indicated in the treatment of NSAID induced dyspepsia. In this case, however, there is no clear description of dyspepsia, either NSAID-induced or stand-alone appreciated on any recent 2013 progress note. Therefore, the request is not certified.

**30 Tramadol ER 150mg between 6/3/2013 and 8/22/2013: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 80.

**Decision rationale:** As noted on page 80 of the MTUS Chronic Medical Treatment Guidelines, the cardinal criteria for continuation of opioid therapy include evidence of successful return to work, improved functioning, and reduced pain effected as a result of ongoing usage. In this case, however, the applicant does not meet any of the aforementioned criteria. The applicant has failed to return to work. The applicant remains off of work, on total temporary disability. There is no evidence of reduced pain scores or improved performance of non-work activities of daily living effected as a result of ongoing tramadol usage. Accordingly, the request is not certified.

**soft lumbar spine brace between 6/3/2013 and 8/22/2013:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 301.

**Decision rationale:** As noted in the MTUS-Adopted ACOEM Guidelines in Chapter 12, lumbar supports are not recommended outside of the acute phase of symptoms relief. In this case, the applicant's date of injury is April 20, 2008. She is several years removed of the date of injury. She is outside of the acute phase of symptom relief. Continued usage of lumbar support is not indicated. It is further noted that the applicant has used this lumbar support in the past and, as with the many other medications and treatments, has failed to effect any lasting benefit or functional improvement through prior usage of the same. The fact that the applicant remains off of work, on total temporary disability, and remains reliant on various medications, surgeries, etc., imply that previous usage of lumbar support was in fact unsuccessful. Accordingly, the request is not certified.