

Case Number:	CM13-0022527		
Date Assigned:	03/14/2014	Date of Injury:	07/20/2007
Decision Date:	05/27/2014	UR Denial Date:	09/03/2013
Priority:	Standard	Application Received:	09/10/2013

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. The expert reviewer is Board Certified in Physical Medicine and Rehabilitation 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 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/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:

The patient is a 54 year old male injured on 07/20/07 while carrying a sheet of plywood and twisted noting immediate onset of low back and right shoulder pain. The patient underwent conservative treatment including physical therapy and multiple epidural steroid injections ultimately leading to lumbar surgery on 01/28/10. The patient had modest benefit following surgery; however, did not completely alleviate low back and right leg pain. Current diagnoses included spondylolisthesis, post-operative chronic pain, lumbosacral and thoracic neuritis, and shoulder tendinitis. Clinical note dated 02/19/14 indicated the patient presented with low back and right shoulder pain with associated numbness and cramping in his legs, left greater than right. The patient reported pain was worse on cold days. He attempted to walk regularly and utilized ice/heat to control his pain. The patient utilized medications as needed and found them helpful to control his pain temporarily. The patient reported he was seen for psychological evaluation in 01/14 and underwent urological evaluation in October/November 2013. The patient indicated he was prescribed medication for erectile dysfunction however had not had any additional treatment. Physical examination revealed decreased lumbar range of motion, tenderness to palpation of the lumbar paraspinal musculature, and right traps, reduced sensation to the left lower extremity, with no suicidal ideation. Clinical note dated 02/22/14 indicated the patient was establishing care as primary treating physician. The patient reported low back and right shoulder pain radiating into bilateral legs with paresthesias. Utilization of lidopro and other medications (not specified) was documented. The patient also continued his home exercise program and use of TENS unit to help with ongoing pain. It was documented that the patient was attending school and having difficulty remaining seated.

IMR ISSUES, DECISIONS AND RATIONALES

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

PRESCRIPTION OF CYCLOBENZAPRINE 7.5MG, #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxant Page(s): 63-64.

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

Decision rationale: As noted on page 41 of the Chronic Pain Medical Treatment Guidelines, Cyclobenzaprine is recommended as a second-line option for short-term (less than two weeks) treatment of acute low back pain and for short-term treatment of acute exacerbations in patients with chronic low back pain. Studies have shown that the efficacy appears to diminish over time, and prolonged use of some medications in this class may lead to dependence. Based on the clinical documentation, the patient has exceeded the 2-4 week window for acute management indicating a lack of efficacy if being utilized for chronic flare-ups. The request for Cyclobenzaprine 7.5MG is not medically necessary.

RETROSPECTIVE REQUEST FOR PRESCRIPTION OF MENTHODERM 120GM: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Salicylate, Topical Analgesics Page(s): 105, 111-113. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Treatment Index, 11th Edition(web), 2013, Pain Chapter, Salicylate Topicals.

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

Decision rationale: As noted on page 111 of the Chronic Pain Medical Treatment Guidelines, the safety and efficacy of compounded medications has not been established through rigorous clinical trials. Topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. There is no indication in the documentation that these types of medications have been trialed and/or failed. Additionally, there is no indication that there are contraindications to the readily available over-the-counter formulation of this medication. The request for Mentherm 120gm is not medically necessary.

RETROSPECTIVE REQUEST FOR TENS PATCH X 2 PAIRS: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous Electrical Nerve Stimulation (TENS), Page(s): 8-9,.

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

Decision rationale: As noted on page 114 of the Chronic Pain Medical Treatment Guidelines, TENS units are not recommended as a primary treatment modality, but may be considered as a noninvasive conservative option, if used as an adjunct to a program of evidence-based functional restoration. The patient is actively participating in a home exercise program and utilizing appropriate medication management. The documentation indicates the patient experiences significant benefits from the use of the TENS unit. As such, the request for TENS Patch X 2 Pairs is medically necessary.

PRESCRIPTION TRIAL OF CIALIS 5MG #10: 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), Treatment Index, 11th Edition(web), 2013, Pain Chapter, Testosterone Replacement for hypogonadism(related to opioids), and The American Urological Association Treatment Guidelines.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation OTHER MEDICAL TREATMENT GUIDELINE OR MEDICAL EVIDENCE:
[HTTP://WWW.NLM.NIH.GOV/MEDLINEPLUS/DRUGINFO/MEDS/A604008.HTML](http://www.nlm.nih.gov/medlineplus/druginfo/meds/a604008.html)

Decision rationale: Based on information provided, the clinical note indicated that the patient was evaluated for complaints of erectile dysfunction; however, there was insufficient documentation to indicate that the diagnosis was directly related to the initial injury. Additionally, there is no indication that medication adjustments have been attempted prior to additional prescriptions if the disorder is believed to be related to adverse effects. As such, the request for Prescription Trial of Cialis 5mg #10 is not medically necessary.