

Case Number:	CM13-0039116		
Date Assigned:	12/18/2013	Date of Injury:	02/05/2013
Decision Date:	02/13/2014	UR Denial Date:	09/06/2013
Priority:	Standard	Application Received:	10/02/2013

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 Family Practice 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:

The patient is a 55-year-old female who reported a work related injury on 02/05/2013, due to cumulative stress injury. The patient presents for treatment of the following diagnoses: right shoulder/right upper extremity diminished range of motion, lumbosacral sprain/strain, lumbosacral syndrome, bilateral knee pain, bilateral wrist complaints, and rule out rheumatoid arthritis. The clinical note dated 08/29/2013 signed by [REDACTED] documents the patient presented with complaints of 9/10 pain across the whole back, with radiation of pain into the buttocks. The provider documented, upon physical exam of the patient, 5/5 motor strength was noted throughout, with decreased range of motion to the lumbar spine, flexion at 50 degrees, extension at 5 degrees, 25 degrees bilateral/lateral bend, 30 degrees rotation. The provider documented the patient was requesting a 3 inch memory foam pad for her bed due to her back.

IMR ISSUES, DECISIONS AND RATIONALES

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

Request for 3" Memory Foam for bed: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM. Decision based on Non-MTUS Citation ODG 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 chapter

Decision rationale: The current request is not supported. Clinical documentation fails to evidence the medical necessity of the patient's current request. Official Disability Guidelines indicate mattress selection is subjective and depends on personal preference and individual factors. There are no high-quality studies to support purchase of any type of specialized mattress or bedding as a treatment for low back pain. Given the above, the request for a 3-inch memory foam mattress for the bed is not medically necessary or appropriate.

Request for prescription of Celebrex 200mg QTY: 30.00: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 60, 67.

Decision rationale: The requested Celebrex 200 mg quantity 30 is not medically necessary or appropriate. California Medical Treatment Utilization Schedule recommends the continued use of medications in the management of a patient's chronic pain be supported by evidence of pain relief and functional benefit. The clinical documentation submitted for review does provide evidence that the patient has been on this medication for an extended duration of time. The patient's most recent clinical evaluation reveals that the patient has 9/10 pain without medications that is reduced to 5/10 with medications. However, the documentation does not provide any evidence of significant functional benefit as a result of medication usage. Therefore, continued use is not supported. As such, the requested Celebrex 200 mg quantity 30 is not medically necessary or appropriate.

Request for prescription of Terocin 120ml QTY: 1.00: Upheld

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

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

Decision rationale: The requested Terocin 120 mL quantity 1 is not medically necessary or appropriate. The requested medication contains methyl salicylate, capsaicin, menthol and Lidocaine. California Medical Treatment Utilization Schedule does recommend the use of methyl salicylate and menthol as a topical agent for osteoarthritic pain. However, the clinical documentation submitted for review does not support that the patient has evidence of osteoarthritic pain. California Medical Treatment Utilization Schedule also only recommends capsaicin for patients who are intolerant to other treatments. The clinical documentation submitted for review does not provide evidence that the patient has exhausted all other types of treatments to support the use of topical capsaicin. Additionally, the California Medical Treatment Utilization Schedule does not support the use of Lidocaine in a cream formulation as it is not FDA approved for neuropathic pain. California Medical Treatment Utilization Schedule does not recommend the use of any medication that contains one drug or drug class that is not

recommended. As this medication contains a cream formulation of Lidocaine, it would not be supported by guideline recommendations. As such, the requested Terocin lotion 120 ml quantity 1 is not medically necessary or appropriate.