

Case Number:	CM14-0132622		
Date Assigned:	08/22/2014	Date of Injury:	04/05/2012
Decision Date:	10/01/2014	UR Denial Date:	07/31/2014
Priority:	Standard	Application Received:	08/19/2014

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 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 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:

Patient is a 30 year-old with date of injury 04/05/2012. The medical document associated with the request for authorization, a primary treating physician's progress report, dated 07/4/2014, lists subjective complaints as constant low back pain. Objective findings: Examination of the lumbar spine revealed full range of motion with pain on extension and right side bending. There is full range of motion of the cervical spine with a negative Spurling's sign. Motor strength was 5/5 and equal in upper extremity and lower extremity. Patient had multiple trigger points in the neck and shoulder girdle, low back, and hip girdle. She was especially tender in the quadratus lumborum muscles. Diagnosis include: chronic pain syndrome, myofascial pain syndrome, low back pain, rotator cuff injury, calcific tendinitis, and sprain sacroiliac nos. The medical records supplied for review document that the patient has been prescribed Lidoderm patches for two months and Flexeril, Tramadol, and Nabumetone (as Relafen) for at least as far back as 6 months.

IMR ISSUES, DECISIONS AND RATIONALES

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

Lumbar Corset (rental or purchase): Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 301. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back Procedure Summary

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

Decision rationale: According to the MTUS, lumbar supports have not been shown to have any lasting benefit beyond the acute phase of symptom relief. Given that, the request for Lumbar Corset (rental or purchase) is not medically necessary.

Theracane (rental or purchase): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Blue Cross of California Medical Policy Durable Medical Equipment CG-DME-10Centers for Medicare & Medicaid Services (CMS)

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Blue Cross Clinical UM Guideline, Durable Medical Equipment, Guideline #: CG-DME-10, Last Review Date: 02/13/2014

Decision rationale: According to the Blue Cross Clinical UM Guideline for Durable Medical Equipment, durable medical equipment is considered medically necessary when all of a number of criteria are met including, there is a clinical assessment and associated rationale for the requested DME in the home setting, as evaluated by a physician, licensed physical therapist, occupational therapist, or nurse; and there is documentation substantiating that the DME is clinically appropriate, in terms of type, quantity, frequency, extent, site and duration and is considered effective for the individual's illness, injury or disease; and the documentation supports that the requested DME will restore or facilitate participation in the individual's usual IADL's and life roles. There is insufficient documentation in the medical record. The request for a Thera Cane is not medically necessary.

Nabumetone 750 mg #60 with 2 refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Nonsteroidal Anti-Inflammatory Drugs (NSAIDs).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 71-72.

Decision rationale: Nabumetone (Relafen) is a Nonsteroidal anti-inflammatory drugs (NSAIDs) typically prescribed for osteoarthritis. The MTUS recommends that NSAIDs be used at the lowest dose for the shortest period in patients with moderate to severe pain. The medical record fails to provide documentation of objective functional improvement from taking Nabumetone. The request for Nabumetone 750 mg #60 with 2 refills is not medically necessary.

Lidoderm 5% patch #30 with 2 refills: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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

Decision rationale: According to the MTUS, Lidoderm 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). This is not a first-line treatment and is only FDA approved for post-herpetic neuralgia. The medical record has no documentation that the patient has undergone a trial of first-line therapy. The request for Lidoderm 5% patch #30 with 2 refills is not medically necessary.

Flexeril 10 mg #20 with no refills: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Pain Procedure Summary, Muscle relaxants

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 64.

Decision rationale: The previous utilization review decision provided a sufficient quantity of Flexeril to allow a short course of treatment. The Chronic Pain Treatment Guidelines do not recommend long-term use of muscle relaxants. There is no documented functional improvement from any previous use in this patient. The MTUS also state that muscle relaxants are no more effective than NSAID's alone. Based on the currently available information, the medical necessity for this muscle relaxant medication has not been established. The request for Flexeril 10 mg #20 with no refills is not medically necessary.

Tramadol 50 mg #60 with no refills: Upheld

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

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

Decision rationale: The Chronic Pain Medical Treatment Guidelines state that continued or long-term use of opioids should be based on documented pain relief and functional improvement or improved quality of life. Tramadol is a centrally acting synthetic opioid analgesic and it is not recommended as a first-line oral analgesic. There is no documentation of functional improvement supporting the continued long-term use of opioids. The request for Tramadol 50 mg #60 with no refills is not medically necessary.