

Case Number:	CM14-0143187		
Date Assigned:	10/31/2014	Date of Injury:	03/31/2014
Decision Date:	12/08/2014	UR Denial Date:	07/30/2014
Priority:	Standard	Application Received:	09/04/2014

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 Physical Medicine and Rehabilitation, has a subspecialty in Interventional Spine 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 53-year-old female with a date of injury of 03/31/2014. The listed diagnoses per [REDACTED] are: 1. Lumbar disk displacement without myelopathy. 2. Right hip sprain/strain. 3. Sacroiliitis. According to progress report 07/09/2014, the patient presents with constant moderate to severe pain in the lower back which radiates to her buttocks and right hip. Examination of the lumbar spine revealed +3 spasm and tenderness to the bilateral lumbar paraspinal muscle from L3 to S1, multifidus and right piriformis muscle. Range of motion was decreased. Kemp's test and straight leg raise tests were both positive. Examination of the right hip revealed +3 spasm and tenderness to the right gluteal medius muscle and right tensor fasciae latae muscle. Range of motion was decreased. FABER's test and Anvil tests were both positive on the right. The treater is requesting 10 visits of work hardening program, topical creams, and Tylenol No. 3 #60 with 2 refills. The patient is currently not working and last worked on 04/16/2014. Utilization review denied the request on 07/30/2014. Treatment reports from 04/17/2014 through 07/09/2014 were reviewed.

IMR ISSUES, DECISIONS AND RATIONALES

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

Work hardening x 10 visits to low back & right hip: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Work conditioning, Page(s): 125.

Decision rationale: This patient presents with low back and right hip pain. The treater is requesting work hardening x10 visits. Treater states the patient's goals in the work hardening program is to increase activities of daily living, and decrease need for medication. MTUS page 125 states Work conditioning, work hardening programs are recommended as an option depending on the availability of quality programs. Criteria for admission to Work Hardening Program include (2) "After treatment with an adequate trail of physical or occupational therapy with improvement followed by plateau, but not likely to benefit from continue physical or occupational therapy."; (3), "Not a candidate where surgery or other treatments would clearly be warranted to improve function."; (5), a documented specific job to return to; and (6), "Approval of these programs should require a screening process that includes file review, interview and testing to determine likelihood of success in the program." In this case, a screening process prior to consideration has not taken place. Furthermore, there is no evidence that there is a specific job to return to. This request is not medically necessary.

Lidocaine 6%, Gabapentin 10%, Tramadol 10%, quantity 2 refills: 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: This patient presents with low back and right hip pain. The treater is requesting a topical compound cream that includes lidocaine 6%, gabapentin 10%, and tramadol 10% with 2 refills. The MTUS Guidelines p 111 has the following regarding topical creams, "topical analgesics are largely experimental and used with few randomized control trials to determine efficacy or safety." MTUS further states, "Any compounded product that contains at least one (or drug class) that is not recommended is not recommended." Per MTUS, Lidocaine is only allowed in a patch form and not allowed in cream, lotion or gel forms. Furthermore, Gabapentin is not recommended in any topical formulation. This request is not medically necessary.

Flurbiprofen 15%, Cyclobenzaprine 2%, Baclofen 2%, Lidocaine 5%, quantity 180gm, 2 refills: 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: This patient presents with low back pain and right hip pain. The treater is requesting compound topical cream that includes flurbiprofen 15%, cyclobenzaprine 2%, baclofen 2%, and lidocaine 5% 180 g with 2 refills. The MTUS Guidelines p 111 has the following regarding topical creams, "topical analgesics are largely experimental and used with few randomized control trials to determine efficacy or safety." MTUS further states, "Any compounded product that contains at least one (or drug class) that is not recommended is not recommended." Per MTUS, Lidocaine is only allowed in a patch form and not allowed in cream, lotion or gel forms. Furthermore, cyclobenzaprine is a muscle relaxant and not recommended for topical formulation. This request is not medically necessary.

Tylenol 3 #60, 2 refills: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines CRITERIA FOR USE OF OPIOIDS Page(s): 88, 89, 76-78.

Decision rationale: This patient presents with low back and right hip pain. The treater is requesting Tylenol No. 3 #60 with 2 refills. The medical file provided for review includes 2 progress reports from 04/17/2014 and 07/09/2014. The only discussion regarding Tylenol No. 3 is on report 07/09/2014, in which the treater prescribed "Tylenol No. 3 #60. Sig: 1 q. 4-6H, p.r.n. for pain with 2 refills." The MTUS guidelines pg 76-78, criteria for initiating opioids recommends that reasonable alternatives have been tried, consider patient's likelihood of improvement, likelihood of abuse, etc. MTUS goes on to state that baseline pain and functional assessments should be made. Once the criteria have been met a new course of opioids may be tried at that time. In this case, the treater does not provide baseline pain or functional assessments to necessitate a start of a new opioid. This request is not medically necessary.