

Case Number:	CM14-0161630		
Date Assigned:	10/07/2014	Date of Injury:	09/12/2011
Decision Date:	11/10/2014	UR Denial Date:	09/09/2014
Priority:	Standard	Application Received:	10/01/2014

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 Pain Medicine and is licensed to practice in Texas. 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 injured worker is a 26-year-old male who reported an injury on 09/12/2011 who reportedly reached to prevent a bin from falling off the truck and injured his lower back. The medical records were reviewed. On 09/09/2014, the injured worker presented with complaints of low back pain that radiates to the bilateral legs, right greater than left. Upon examination, decreased range of motion and spasm was noted and a limp upon ambulation. Decreased sensation to the right L5 and S1 dermatomes was noted. The diagnosis was lumbar right SI joint sprain/strain with radiculitis. Prior therapy included spinal decompression sessions. The provider recommended tramadol, Biofreeze, and a functional restoration program evaluation, the provider's rationale was not provided. The Request for Authorization form was not included in the medical documents for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Tramadol 50 Mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Therapeutic Trial of Opioids.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Criteria for use Page(s): 78.

Decision rationale: The request for Tramadol is not medically necessary. The California MTUS Guidelines recommend the use of opioids for ongoing management of chronic pain. The guidelines recommend ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects should be evident. There is lack of evidence of an objective assessment of the injured worker's pain level, functional status, and evaluation of risk for aberrant drug abuse behavior and side effects. Additionally, the provider's request does not indicate the frequency of the medication in the request as submitted. As such, medical necessity has not been established.

Biofreeze (#1 Tube): 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 Topical Analgesics Page(s): 111.

Decision rationale: The request for Biofreeze (#1 tube) is not medically necessary. The California MTUS Guidelines state that transdermal compounds are largely experimental in use with few randomized controlled trials to determine efficacy or safety. Topical analgesics are primarily recommended for neuropathic pain when trails of antidepressants and anticonvulsants have failed. Many agents are compounded as monotherapy or in combination for pain control (including NSAIDs, opioids, capsaicin, local anesthetics, antidepressants, glutamate receptor antagonists). There is little to no research to support the use of many of these agents. Additionally, the provider's request did not indicate the dose, frequency or site at which the Biofreeze is indicated for the request as submitted. As such, medical necessity has not been established.

Functional Restoration Program Evaluation: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 5 Cornerstones of Disability Prevention and Management Page(s): 77-89. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Fitness for Duty, Functional Capacity Evaluation

Decision rationale: The request for a functional restoration program evaluation is not medically necessary. The California MTUS/ACOEM Guidelines state that Functional Capacity Evaluation may be necessary to obtain a more precise delineation of the injured worker's capabilities. The Official Disability Guidelines further state that a Functional Capacity Evaluation is recommended and may be used prior to admission to a work hardening program for specific job or task. Functional Capacity Evaluations are not recommended. There is lack of documentation of objective findings upon physical examination demonstrating significant functional deficit. The documentation lacked evidence on how a Functional Capacity Evaluation will aid the provider in a treatment plan or goals. There is also a lack of documentation of other treatments the injured

worker underwent previously and the measurement of progress as well as efficacy of the prior treatments. As such, medical necessity has not been established.