MAXIMUS Federal Services

Case Number:	CM14-0020540		
Date Assigned:	02/21/2014	Date of Injury:	06/18/2010
Decision Date:	07/22/2014	UR Denial Date:	02/06/2014
Priority:	Standard	Application Received:	02/19/2014

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 Anesthesiology, has a subspecialty in Pain Management and is licensed to practice in Tennessee. 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 58-year-old male who has filed a claim for lumbar degenerative disc disease associated with an industrial injury date of June 18, 2010. Review of progress notes indicates mild to moderate back pain intermittently radiating to the hips and legs. Patient reports good benefit from chiropractic therapy, Flector patches, tramadol, Anaprox, and Soma. Findings include visible and palpable lumbar spasm, and mildly positive bilateral straight leg raise test. Treatment to date has included Non-steroidal anti-inflammatory drug (NSAIDs), opioids, muscle relaxants, physical therapy, chiropractic therapy, facet injections, lumbar support, work hardening program, right shoulder arthroscopic surgery, and right knee arthroscopic surgery. Utilization review from February 06, 2014 denied the requests for Soma 350mg #100 with 1 refill as it is not recommended, and Flector patches 1.3% #100 with 1 refill as there is no indication for use of this for chronic conditions. There was modified certification for chiropractic therapy for the low back for 6 sessions for a trial course, and for Ultram 50mg for #120 as there is no documentation of functional gains with this medication.

IMR ISSUES, DECISIONS AND RATIONALES

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

CHIROPRACTIC ONE TIMES TWELVE FOR LOW BACK PAIN: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 298-299.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy & manipulation Page(s): 58.

Decision rationale: California Medical Treatment Utilization Schedule (MTUS) Chronic Pain Medical Treatment Guidelines state that the goal of manual therapy is to achieve positive symptomatic or objective measurable functional improvement that facilitate progression in the patient's therapeutic exercise program and return to productive activities. For the low back, trial of 6 visits is recommended, and with evidence of objective functional improvement, a total of up to 18 visits is supported. In addition, elective/maintenance care is not medically necessary. This patient has had previous chiropractic visits, the latest in 2010. Patient reported good benefit from chiropractic sessions. An initial course of 6 visits is recommended, with additional visits upon evidence of functional benefits. The requested quantity exceeds guideline recommendations. Therefore, the request for chiropractic one times twelve for low back pain was not medically necessary.

SOMA 350MG, 1 BY MOUTH TWICE A DAY, 100 WITH ONE REFILL: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Carisoprodol (Soma); and Muscle relaxants (for pain), Carisoprodol (Soma, Soprodal 350, Vanadom, generic available) Page(s): 29,65.

Decision rationale: Pages 29 and 65 of California Medical Treatment Utilization Schedule (MTUS) Chronic Pain Medical Treatment Guidelines state that Soma is not recommended. It is not recommended for use longer than 2-3 weeks. Carisoprodol is metabolized to meprobamate an anxiolytic that is a schedule IV controlled substance. There is note that the patient has been using this medication since at least January 2014; the limited documentation does not indicate when the patient started using this medication. However, this medication is not recommended for use. Therefore, the request for Soma 350mg #100 with 1 refill was not medically necessary.

FLECTOR PATCHES 1.3% 1 TWICE A DAY, #100 WITH ONE REFILL: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Non-steroidal anti-inflammatory drug (NSAIDS) Page(s): 111-112.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics, Non-steroidal antinflammatory agents (NSAIDs) Page(s): 111-112.

Decision rationale: California Medical Treatment Utilization Schedule (MTUS) Chronic Pain Medical Treatment Guidelines states that topical NSAIDs have been shown in meta-analysis to be superior to placebo during the first 2 weeks of treatment for osteoarthritis, but either not afterward or with a diminishing effect over another 2-week period. There is little evidence to utilize topical NSAIDs for treatment of osteoarthritis of the spine, hip, or shoulder. The patient is being prescribed this medication due to GI side effects and potential renal side effects from anti-

inflammatory medications. There is note that the patient has been using this medication since at least January 2014; the limited documentation does not indicate when the patient started using this medication. However, the patient presents with a lumbar spinal condition, for which this medication is not indicated. Therefore, the request for Flector patches 1.3% #100 with 1 refill was not medically necessary.

ULTRAM FOR PAIN, 50MG, 1-2 EVERY 4-6 HOURS, #200 WITH ONE REFILL.: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

Decision rationale: As noted on page 78-82 of the California Medical Treatment Utilization Schedule (MTUS) Chronic Pain Medical Treatment Guidelines, there is no support for ongoing opioid treatment unless there is ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. There is note that the patient has been using this medication since at least January 2014; the limited documentation does not indicate when the patient started using this medication. There is no documentation of objective functional benefits derived from this medication, or of periodic urine drug screens for medication monitoring. Also, additional refills are not indicated unless continued measured objective benefits are documented. Therefore, the request for Ultram 50mg #200 with one refill was not medically necessary.