MAXIMUS Federal Services

Case Number:	CM14-0024409		
Date Assigned:	06/11/2014	Date of Injury:	09/12/2012
Decision Date:	08/06/2014	UR Denial Date:	02/13/2014
Priority:	Standard	Application Received:	02/26/2014

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 and Pain Medicine, has a subspecialty in Pain 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:

This is a 62-year-old female who sustained a remote industrial injury on 09/12/12 diagnosed with degenerative disc disorder of the lumbar spine and left lateral malleolus. Mechanism of injury is not specified. The requests for Flexeril 7.5mg at bedtime as needed, Ibuprofen 800mg twice a day as needed, Prilosec 30mg daily, and Cyclo-Keto-Lido topical compound as needed were non-certified at utilization review due to the intermittent and inconsistent nature of the use of medications on a daily basis not being clinically effective or medically necessary and the patient appears to be making steady progress. The request for a cane (replacement) was also non-certified at utilization review due to the lack of documentation concerning the patient's need for assisted ambulation with a cane and concerning the circumstances behind how a device that is medically necessary is lost. The most recent progress note provided is 10/31/13. This progress report is handwritten and barely legible. It appears the patient complains primarily of chronic lumbar spine pain rated as a 7/10 with the low back locking up at times and throbbing left ankle pain rated as a 4-5/10. Patient reports stress, anxiety, depression, sleep disturbance, an antalgic gait, stiff movements, and she is obese. The patient does not report utilizing an assistive device. Physical exam findings reveal tenderness and spasm in the lumbosacral spine and lateral ankle pain. Current medications include: Ibuprofen and Cyclobenzaprine. It is noted that the treating physician is requesting physical therapy, acupuncture, and a left ankle brace. Provided documents include an Agreed Medical Examiner Supplemental report and a previous progress report. The patient's previous treatments include physical therapy and medication. Imaging studies provided include an MRI of the lumbar spine, performed on 02/19/13. The impression of this MRI reveals compression deformity of L3 vertebral body; disc desiccation at L2-3 down to L5-S1 with associated loss of disc height; and disc bulges at L2-3, L3-4, L4-5, and L5-S1 with

concurrent bilateral facet degenerative change as well as bilateral ligamentum flavum hypertrophy which causes bilateral neural foraminal narrowing, spinal canal narrowing, and bilateral lateral recess stenosis. An MRI of the left lower extremity, performed on 06/20/13, reveals a nondisplaced fracture at the lateral malleolus with mild surrounding bone marrow edema; remote injury involving the deep portion of the deltoid ligamentous complex; and mild atrophy of the abductor digit minimal muscle.

IMR ISSUES, DECISIONS AND RATIONALES

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

CANE (REPLACEMENT): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Ankle and Foot, Walking Aids.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee and Leg, Walking aids (canes, crutches, braces, orthoses, & walkers).

Decision rationale: According to ODG, the use of Walking aids is recommended. In regards to the use of a cane, the use of this aid is most efficacious for persons with knee osteoarthritis but can be utilized to reduce pain when used for ambulation purposes. In this case, provided documentation does not highlight the patient to have a diagnosis of knee osteoarthritis but an antalgic gait is noted. However, the treating phsycian does not provide a rationale behind the request for a cane, and more specifically, the provider does not highlight the medical necessity of a replacement cane, as the mechanism of its misplacement is not specified and the efficacy of its previous use is not described. Thus, the request for cane (replacement) is not medically necessary.

PRESCRIPTION OF FLEXERIL 7.5MG, AT BEDTIME AS NEEDED: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Cyclobenzaprine (Flexeril) Page(s): 41-42.

Decision rationale: According to MTUS guidelines on Flexeril, the effect is greatest in the first 4 days of treatment, suggesting that shorter courses may be better. In this case, provided documentation does not highlight how long the patient has been utilizing Flexeril and chronic use of a muscle relaxant is not supported by guidelines. Although the patient reportedly has muscle spasms, there is no documentation of significant functional benefit with the use of Flexeril. Furthermore, the quantity and frequency of the requested medication is not specified in this request. For these reasons, the request for Flexeril 7.5mg, at bedtime as needed is not medically necessary.

PRESCRIPTION OF IBUPROFEN 800MG, TWICE A DAY, AS NEEDED: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs (non-steroidal anti-inflammatory drugs).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs (non-steroidal anti-inflammatory drugs) Page(s): 67-68.

Decision rationale: Documentation provided for review does not identify significant functional/vocational benefit with the use of this NSAID and CA MTUS guidelines indicate this should be used at the lowest dose possible for the shortest duration possible for moderate to severe pain. Given the patient's lack of efficacy and prescription that specifies as needed, ongoing chronic NSAID use would not be supported as medically necessary. Further, provided documentation does not indicate how long the patient has been taking this NSAID. Lastly, the quantity and frequency of the requested medication is not specified in this request. Thus, the request for Ibuprofen 800mg, twice a day, as needed is not medically necessary.

PRESCRIPTION OF PRILOSEC 20MG, DAILY: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk Page(s): 68-69.

Decision rationale: According to CA MTUS guidelines, the use of Proton Pump Inhibitors is recommended for patients with a high risk of gastrointestinal complications determined by the following criteria: (1) age > 65 years; (2) history of peptic ulcer, GI bleeding or perforation; (3) concurrent use of ASA, corticosteroids, and/or an anticoagulant; or (4) high dose/multiple NSAID (e.g., NSAID + low-dose ASA). In this case, the treating physician does not document any of the listed criteria for gastrointestinal complications and the medical necessity of the use of an NSAID is also not supported in the current clinical setting. Furthermore, the quantity and frequency of the requested medication is not specified in this request. As such, the request for Prilosec 20mg, daily is not medically necessary.

PRESCRIPTION FOR TOPICAL COMPOUND OF CYCLO - KETO - LIDO, USE AS NEEDED: 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): 111-113.

Decision rationale: When assessing the medical necessity of topical medications, CA MTUS is utilized, which notes that topical application of medications is largely experimental. According to MTUS guidelines, Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. In regards to the requested compound, there is no evidence to support topical application of muscle relaxants such as Cyclobenzaprine as efficacious. Also, topical Lidocaine is only indicated after there has been a failure of readily available oral agents in the antidepressant, antiepileptic, or non-steroidal anti-inflammatory class, which has not been described in the current clincal setting. Furthermore, the quantity and frequency of the requested medication is not specified in this request. As such, the request for topical compound of Cyclo - Keto - Lido, use as needed is not medically necessary.