

Case Number:	CM14-0029527		
Date Assigned:	06/16/2014	Date of Injury:	06/27/2003
Decision Date:	07/28/2014	UR Denial Date:	02/26/2014
Priority:	Standard	Application Received:	03/07/2014

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 54-year-old male with a date of injury of 06/27/2003. The listed diagnoses per [REDACTED] are lower spine retrolisthesis and hospice and palliative medicine, L4-L5 disk protrusion and spinal canal stenosis and lower back pain with bilateral lower extremity radiculopathy. According to progress report, 02/19/2014 by [REDACTED], the patient presents with chronic low back pain. The patient rates the pain at 8/10 in intensity. The progress report 01/20/2014 indicates the patient has lower back pain with spasm. The patient also reports painful gait and bilateral buttocks and thigh numbness. The physician states patient has gastritis and stress from taking chronic medication. This is a request for 1 lumbar brace, Amitramadol cream 240 g with refill and Cyclo/Keto/Lido 240 g with 1 refill. Utilization review denied the request on 02/26/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 LUMBAR SACRAL ORTHOSIS BRACE: Overturned

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 301. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

Decision rationale: This patient presents with chronic low back pain. The physician is requesting a Lumbosacral brace. The utilization review denied the request stating "there is no evidence for the effectiveness of lumbar supports in preventing back pain." The ACOEM guidelines page 301 on lumbar bracing states, "Lumbar supports have not been shown to have any lasting benefit beyond the acute phase of symptom relief." The ODG guidelines regarding lumbar support states, "Not recommended for prevention; however, recommended as an option for compression fracture and specific treatment of spondylolisthesis, documented instability, and for treatment of nonspecific low back pain (very low-quality evidence, but may be a conservative option)." In this case, the patient does not present with fracture, instability, but does have retrolisthesis for which ODG guidelines support lumbar bracing. Therefore the request is medically necessary.

1 AMITRAMADOL CREAM ,240 GM WITH REFILL: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111.

Decision rationale: This patient presents with chronic low back pain. The physician is requesting compound topical cream, Amitramadol 240 mg with refill. The MTUS Guidelines page 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." In this case, Tramadol is not tested for transdermal use with any efficacy. The recommended compound topical cream is not medically necessary.

1 CYCLO -KETO-LIDO ,240 GM WITH REFILL: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111.

Decision rationale: This patient presents with chronic low back pain. The physician is requesting a topical compound cream including Cyclobenzaprine, Ketamine, and Lidocaine 240 mg with refill. The MTUS Guidelines regarding topical analgesics states that it is "Largely experimental in use with few randomized controlled 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." According to the MTUS Guidelines, Cyclobenzaprine is a muscle relaxant and is not recommended for any topical formulation. Therefore the request is not medically necessary.