

Case Number:	CM14-0032329		
Date Assigned:	06/20/2014	Date of Injury:	11/22/2012
Decision Date:	07/22/2014	UR Denial Date:	02/13/2014
Priority:	Standard	Application Received:	03/13/2014

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 Occupational 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 49 year old female who suffered a work related injury on 11/22/12 when she helped her client move from his bed to the wheelchair. She lifted his leg and had immediate onset of acute low back and slight right shoulder pain. She continued to work through that day with persistent low back and right shoulder pain. She was diagnosed acutely with lumbosacral strain. She was treated initially with medications and five physical therapy sessions without relief. 02/18/13 electrodiagnostic studies reported no abnormalities. Magnetic resonance imaging (MRI) scan of lumbar spine on 03/20/13 revealed 2mm L4-5 disc protrusion and 4mm L5-S1 disc protrusion with no nerve root compression. The injured worker had seen pain management specialist, she went through functional restoration for 120 hours with some pain relief. The injured worker had follow up MRI on 11/11/13 because of continued left lumbar radiculopathy which, revealed no changes since previous lumbar MRI scan. Progress note on 12/20/13, patient reported pain that was persistent, she presented with bilateral low back pain radiating into her left lower extremity. She described it as burning, numbness and tingling. Present pain score was 7/10. Pain was constant but variable in intensity. She is aggravated by any activities alleviated by medication and rest. She continued to do her home exercise program. Physical examination antalgic gait favors the left. No documentation of functional improvement, or decrease in pain intensity. Diagnosis was fibromyositis. Low back pain. Chronic pain syndrome. Depressive disorder. Request was for baclofen 10mg #120. Flector 1.3% transdermal 12 hour patch #60. Prior utilization review dated 02/13/04 which was non-certified.

IMR ISSUES, DECISIONS AND RATIONALES

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

Baclofen 10mg #120: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Baclofen.

Decision rationale: The request for Baclofen 10 mg #120 is not medically necessary. Baclofen is recommended for the treatment of spasticity and muscle spasm related to multiple sclerosis, and spinal cord injuries. The clinical documentation submitted does not support the request for baclofen. Therefore, medical necessity has not been established.

Flector 1.3% transdermal twelve (12) hour patch #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAID Page(s): 67-73. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Flector patch.

Decision rationale: The request for Flector patch is not medically necessary. Not recommended as a first-line treatment. Flector patch is Food and Drug Administration (FDA) indicated for acute strains, sprains, and contusions. Flector patch is recommended for osteoarthritis after failure of an oral non-steroidal anti-inflammatory drug (NSAID) or contraindications to oral NSAIDs. The clinical documentation submitted does not support the request for Flector patch. Therefore medical necessity has not been established.