

<b>Case Number:</b>	CM14-0061404		
<b>Date Assigned:</b>	09/03/2014	<b>Date of Injury:</b>	12/26/1994
<b>Decision Date:</b>	10/07/2014	<b>UR Denial Date:</b>	04/24/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/02/2014

### 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 is licensed to practice in Nevada. 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 records, presented for review, indicate that this 65-year-old female was reportedly injured on December 26, 1994. The most recent progress note, dated July 8, 2014, indicated that there were ongoing complaints of left shoulder pain, low back pain, and neck pain. The physical examination demonstrated tenderness of the greater occipital nerve and the trapezius muscles without spasms. There was decreased cervical spine range of motion with pain. The examination of the lumbar spine revealed tenderness along the paraspinal muscles and the left SI joint. There was decreased lumbar spine range of motion with pain. There was a decreased right-sided patellar reflex and decreased sensation at the left L4 nerve distribution. Diagnostic nerve conduction studies revealed a right-sided L5 radiculopathy, and an MRI of the lumbar spine revealed multilevel degenerative disc disease and facet arthropathy. Previous treatment included a lumbar spine facet joint block. A request had been made for tramadol, topical flurbiprofen/capsaicin/menthol/camphor, and topical ketoprofen/cyclobenzaprine/lidocaine, and a recliner for home use and was not certified in the pre-authorization process on April 24, 2014.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Prescription for Tramadol:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 82, 113 of 127..

**Decision rationale:** The California MTUS guidelines support the use of tramadol (Ultram) for short-term use after there has been evidence of failure of a first-line option, evidence of moderate to severe pain, and documentation of improvement in function with the medication. A review of the available medical records fails to document any improvement in function or pain level with the previous use of tramadol. As such, the request is not considered medically necessary.

**Prescription for Topical ointment (flurbiprofen/capsaicin/menthol/camphor 10%/0.025%/2%/1%) 120 mg:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111-113 of 127.

**Decision rationale:** According to the California Chronic Pain Medical Treatment Guidelines, the only topical analgesic medications indicated for usage include anti-inflammatories, lidocaine, and capsaicin. There is no known efficacy of any other topical agents. Per the MTUS, when one component of a product is not necessary, the entire product is not medically necessary. Considering this, the request for this medication is not medically necessary.

**Prescription for Topical ointment (ketoprofen/cyclobenzaprine/lidocaine 10%/3%/5%) 120 mg:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111-113 of 127.

**Decision rationale:** According to the California Chronic Pain Medical Treatment Guidelines, the only topical analgesic medications indicated for usage include anti-inflammatories, lidocaine, and capsaicin. There is no known efficacy of any other topical agents including cyclobenzaprine. Per the MTUS, when one component of a product is not necessary, the entire product is not medically necessary. Considering this, the request for flurbiprofen/cyclobenzaprine/lidocaine is not medically necessary.

**Replacement recliner chair for home use:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation  
[http://www.aetna.com/cpb/medical/data/400\\_499/0434.html](http://www.aetna.com/cpb/medical/data/400_499/0434.html)

**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, Durable Medical Equipment, Updated August 25, 2014.

**Decision rationale:** According to the Official Disability Guidelines, items that are considered durable medical equipment are those which are primarily and customarily used to survey medical purpose and, is generally not useful to a person in the absence of an illness or injury. A recliner chair does not meet these criteria. As such, this request for a replacement recliner chair for home use is not medically necessary.