

Case Number:	CM14-0092869		
Date Assigned:	09/22/2014	Date of Injury:	12/22/2008
Decision Date:	12/30/2014	UR Denial Date:	05/19/2014
Priority:	Standard	Application Received:	06/19/2014

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 Physical Medicine & Rehabilitation 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 53-year-old female with a 12/22/08 date of injury. The injury occurred when she was hit by a car while crossing the cross walk at work. She was knocked down on her right hip and low back. According to a progress report dated 5/27/14, the patient complained of back pain that radiated into the legs, rated as a 5-8/10. She also complained of right hip pain that radiated into her lower back and right leg, rated as a 4-8/10, and lasted 50-90% of the time. Objective findings: limited range of motion of thoracolumbar spine, pain with maximum internal and external rotation of right hip, tender over the trochanteric region, generalized swelling below the knee on the left calf down to the left ankle region. Diagnostic impression: direct contusion of right hip, chronic lower back pain with lumbar strain, left lower extremity edema. Treatment to date: medication management, activity modification, injections. A UR decision dated 5/19/14 denied the requests for inversion table trial and flurbiprofen/cyclobenzaprine/menthol cream. Regarding inversion therapy, there is no documentation that the patient is actively participating in a program of evidence-based conservative care to achieve functional restoration. Regarding flurbiprofen/cyclobenzaprine/menthol cream, there is no documentation submitted to indicate that this patient has not responded to or is intolerant to other treatments.

IMR ISSUES, DECISIONS AND RATIONALES

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

Inversion table trial (X weeks) quantity 2: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG (Official Disability Guidelines) Inversion therapy

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

Decision rationale: MTUS states that there is no high-grade scientific evidence to support the effectiveness or ineffectiveness of passive physical modalities such as traction. In addition, ODG states that inversion therapy may be a noninvasive conservative option, if used as an adjunct to a program of evidence-based conservative care to achieve functional restoration. However, in the present case, there is no documentation that the inversion therapy requested would be used as an adjunct to a program of evidence-based functional restoration. In addition, a specific rationale as to why this modality of treatment would be indicated in this patient, such as treatment and functional goals, was not provided. Therefore, the request for Inversion table trial (X weeks) quantity 2 was not medically necessary.

Flurbiprofen/Cyclobenzaprine/Menthol 20/10/4% cream 180gm quantity 1: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 25,28, 111-113.

Decision rationale: CA MTUS Chronic Pain Medical Treatment Guidelines state that ketoprofen, lidocaine (in creams, lotion or gels), capsaicin in anything greater than a 0.025% formulation, baclofen, Boswellia Serrata Resin, and other muscle relaxants, and gabapentin and other antiepilepsy drugs are not recommended for topical applications. In addition, any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. However, in the present case, flurbiprofen and cyclobenzaprine are not recommended by guidelines for use in a topical cream/lotion formulation. A specific rationale identifying why this topical compounded medication would be required in this patient despite lack of guideline support was not provided. Therefore, the request for Flurbiprofen/Cyclobenzaprine/Menthol 20/10/4% cream 180gm quantity 1 was not medically necessary.