

Case Number:	CM15-0020013		
Date Assigned:	02/09/2015	Date of Injury:	07/12/2006
Decision Date:	03/26/2015	UR Denial Date:	01/29/2015
Priority:	Standard	Application Received:	02/03/2015

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
State(s) of Licensure: California, Indiana, New York
Certification(s)/Specialty: Internal Medicine

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 58 year old female, who sustained an industrial injury on 7/12/2006. The diagnoses have included low back pain with left lower extremity radiculopathy secondary to spondylolisthesis, cervical spine pain radiating to the bilateral upper extremities secondary to degenerative disc disease, left shoulder sprain/strain and left ankle sprain/strain. Treatment to date has included trigger point injections and medication. According to the Primary Treating Physician's Progress Report dated 1/16/2015, the injured worker complained of cervical spine pain and left knee pain. She had failed a home exercise program. She had been recommended epidural steroid injection (ESI) but declined. Lower back pain was rated 6/10 with radiation into the left lower extremity and feet. Cervical spine pain was rated 6/10 with radiation into the bilateral upper extremities. Functional status was noted to be worse than the last exam. Treatment plan was for physical therapy and acupuncture. Prescribed medications included Norco, Prilosec, Cyclo/Tramadol cream and Flexeril. Solar care FIR was requested. On 1/29/2015, Utilization Review (UR) modified a request for Solar Care FIR Heating to an off the shelf heating pad. UR non-certified a request for Cyclo-Tramadol cream and Flexeril 7.5mg Quantity 360. The Medical Treatment Utilization Schedule (MTUS) was cited.

IMR ISSUES, DECISIONS AND RATIONALES

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

Solar care FIR heating: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Pain, low back, Heat therapy

Decision rationale: Pursuant to the ACOEM and Official Disability Guidelines, solar FIR heating is not medically necessary. The therapy is recommended as an option. A number of studies show continuous low-level heat wrap therapy is effective for treating low back pain. Heat therapy has been found to be helpful for pain reduction and return to normal function. In this case, the injured worker's working diagnoses are low back pain, left lower extremity radiculopathy secondary to degenerative disc disease; cervical spine pain with bilateral upper extremity radiculopathy secondary to degenerative disc disease; left shoulder strain & strain; and left ankle sprain/strain. The California MTUS-adopted ACOEM Guidelines in Chapter 12, simple, low tech, at home applications of heat and cold are recommended. The ACOEM guidelines do not endorse provision of high-tech solar care heating devices to deliver heat and cold therapy. The attending provider has not offered any compelling rationale or narrative to the request for authorization or the application for independent medical review to try and offset the unfavorable ACOEM recommendation. Consequently, absent guideline recommendations for high-tech solar FIR heating, solar FIR heating is not medically necessary.

Cyclo-tramadol cream, quantity 1: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): (s) 111-112.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical analgesics Page(s): 111-113. Decision based on Non-MTUS Citation Pain section, Topical analgesics

Decision rationale: Pursuant to the Chronic Pain Medical Treatment Guidelines and the Official Disability Guidelines, cyclo-tramadol cream #1 is not medically necessary. Topical analgesics are largely experimental with few controlled trials to determine efficacy and safety. They are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Cyclobenzaprine is not recommended. In this case, the injured worker's working diagnoses are low back pain, left lower extremity radiculopathy secondary to degenerative disc disease; cervical spine pain with bilateral upper extremity radiculopathy secondary to degenerative disc disease; left shoulder strain & strain; and left ankle sprain/strain. Any compounded product contains at least one drug (cyclobenzaprine) that is not recommended is not recommended. Consequently, cyclic tramadol cream is not recommended. Based on the clinical information in the medical record and the peer-reviewed evidence-based guidelines, cyclo-tramadol cream #1 is not medically necessary.

Flexeril 7.5mg quantity 360: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Cyclobenzaprine (Flexeril), Muscle Relaxant Page(s): (s) 41, 64.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants Page(s): 63-66. Decision based on Non-MTUS Citation Pain section, Muscle relaxants

Decision rationale: Pursuant to the Chronic Pain Medical Treatment Guidelines and the Official Disability Guidelines, Flexeril 7.5 mg #360 is not medically necessary. Muscle relaxants are recommended as a second line option short-term (less than two weeks) of acute low back pain and for short-term treatment of acute exacerbations in patients with chronic low back pain. Efficacy appears to diminish over time and prolonged use may lead to dependence. In this case, the injured worker's working diagnoses are low back pain, left lower extremity radiculopathy secondary to degenerative disc disease; cervical spine pain with bilateral upper extremity radiculopathy secondary to degenerative disc disease; left shoulder strain & strain; and left ankle sprain/strain. The documentation states the injured worker was taking Flexeril 7.5 mg as far back as August 29, 2014. Objectively, there were no clinical signs of muscle spasm. Additionally, Flexeril is indicated for short-term (less than two weeks) treatment of acute low back pain or short-term treatment of acute exacerbations of chronic low back pain. The injured worker has been using Flexeril in excess of six months. This is in clear excess of the recommended guidelines. Consequently, absent clinical documentation with objective evidence of muscle spasm in clear excess of the recommended guidelines for short-term use (less than two weeks), Flexeril 7.5 mg #360 is not medically necessary.