

Case Number:	CM14-0142567		
Date Assigned:	09/10/2014	Date of Injury:	03/26/2014
Decision Date:	10/30/2014	UR Denial Date:	08/07/2014
Priority:	Standard	Application Received:	09/03/2014

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, has a subspecialty in Interventional Spines, and is licensed to practice in. 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 47-year-old male with a date of injury of 03/26/2014. The listed diagnoses per [REDACTED] are: 1. Low back pain. 2. Lumbar disk disorder with myelopathy. According to progress report 07/22/2014, the patient presents with bilateral low back pain with intermittent right leg muscle spasm, numbness, and tingling. Examination of the lumbar spine revealed mild to moderate tenderness to palpation on the right with palpable muscle spasms noted. Spinous processes in the right side of the L2, L3, and L4 revealed mild tenderness to palpation. Straight leg raise was positive on the right. There is decreased range of motion on all planes secondary to pain. The treater is requesting medications and a Toradol injection. Utilization review denied the request on 08/07/2014. Treatment reports from 03/26/2014 through 07/22/2014 were reviewed.

IMR ISSUES, DECISIONS AND RATIONALES

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

Nabumetone 750mg #30: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Relafen Package Insert

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines states antiinflammatories, pain assessment Page(s): 22, 60.

Decision rationale: This patient presents with bilateral low back pain with intermittent right leg muscle spasm, numbness, and tingling. The treater is requesting a refill of nabumetone 750 mg #30. For antiinflammatory medication, the MTUS Guidelines page 22 states antiinflammatories are the traditional line of treatment to reduce pain so activity of functional restoration can resume, but long term use may not be warranted. Review of the medical file indicates the patient has been taking this medication since 05/07/2014. Subsequent progress reports provide no discussion of this medications efficacy. MTUS page 60 requires documentation of pain assessment and functional changes when medications are used for chronic pain. The request is not medically necessary.

Toradol 60mg #1: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS Page(s): 67-68, 72-73.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines under Ketorolac, Academic Emergency Medicine volume V Page(s): 72, 118 to 122.

Decision rationale: This patient presents with bilateral low back pain with intermittent right leg muscle spasm, numbness, and tingling. The request is for #1 toradol injection. The MTUS Guidelines page 72 under Ketorolac states: "This medication is not indicated for minor or chronic painful condition." Furthermore, the Academic Emergency Medicine volume V page 118 to 122 states "intramuscular ketorolac versus oral ibuprofen in emergency room department patients with acute pain." Study demonstrated that there is no difference between the two and both provided comparable levels of analgesia in emergency patients presenting with moderate to severe pain. The requested Toradol injection is not medically necessary.

Tramadol HCl 50g #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 93-94,76-80, 124.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines CRITERIA FOR USE OF OPIOIDS Page(s): 88, 89, 78.

Decision rationale: This patient presents with bilateral low back pain with intermittent right leg muscle spasm, numbness, and tingling. The treater is requesting a refill of tramadol HCL 50 mg #30. It appears this is an initial request as prior progress reports do not discuss tramadol. For opiate management, MTUS Guidelines pages 88 and 89 state, "Pain should be assessed at each visit, and functioning should be measured at 6-month intervals using a numerical scale or validated instrument." MTUS page 78 also requires documentation of the 4As (analgesia, ADLs, adverse side effects, and adverse behavior). In this case, there is no pain assessment or outcome measures as required by MTUS for chronic opiate use. There is no discussion of medication efficacy and functional changes are not discussed. Furthermore, there are no discussions of possible side effects and Urine drug screens are not administered. Given the lack of sufficient

documentation regarding efficacy, continuation of this medication cannot be supported. The request is not medically necessary.

Cyclobenzaprine HCl 10g #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 64.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines cyclobenzaprine Page(s): 64.

Decision rationale: This patient presents with bilateral low back pain with intermittent right leg muscle spasm, numbness, and tingling. The treater is requesting a refill of cyclobenzaprine 10 mg #30. The MTUS page 64 states that cyclobenzaprine is recommended for a short course of therapy. Limited mixed evidence does not allow for recommendation for chronic use. Review of the medical file indicates that the patient has been taking Carisoprodol since 03/26/2014. On 07/22/2014, treater recommended cyclobenzaprine 10 mg #30. This is an initial request for Cyclobenzaprine. In this case, this medication is not recommended to be used for longer than 2-3 weeks. Given the treater is requesting #30 for an initial trial, the request is not medically necessary.