

Case Number:	CM15-0068231		
Date Assigned:	04/15/2015	Date of Injury:	08/26/2008
Decision Date:	06/29/2015	UR Denial Date:	03/25/2015
Priority:	Standard	Application Received:	04/10/2015

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
 Certification(s)/Specialty: Emergency 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 60 year old male who sustained an industrial injury on 8/26/08. He has reported initial complaints of back injury with pain. The diagnoses have included chronic low back pain, lumbar degenerative disc disease (DDD), multilevel disc bulging, lumbar stenosis, and sciatica and gait derangement. Treatment to date has included medications, diagnostics, conservative measures and pain management. The diagnostic testing that was performed included Magnetic Resonance Imaging (MRI) of the lumbar spine, urine toxicology screen. The current medications included Norco and Soma. Currently, as per the physician progress note dated 3/17/15, the injured worker complains of back pain that radiates to both arms and limited back motion. The pain was rated the same as last visit, which was 9.5/10 on pain scale. The objective findings revealed that the lying straight leg raise caused severe low back pain, there was poor tolerance to Gaenselen's test maneuver, and there was adaptive myofascial muscle shortening on the hamstring. The urine drug test results were not noted. The physician noted the medications were for chronic pain management and the cane and lumbar brace were to improve endurance of standing and walking. The physician requested treatments Included 1 Cane, 1 Lumbar Brace, 1 Container Of Compound Cream (Flurbiprofen 20% And Lidocaine 5%) And 1 Container Of Compound Cream (Cyclobenzapine 10% And Lidocaine 2%) 4gm.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 Cane: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disabilities Guidelines.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) - Knee, Walking aids (canes, crutches, braces, orthoses, & walkers).

Decision rationale: The requested 1 CANE, is not medically necessary. CA MTUS is silent on this issue. Official Disability Guidelines (ODG) Knee, Walking aids (canes, crutches, braces, orthoses, & walkers) note that these devices are recommended with evidence of significant knee osteoarthritis, knee joint instability of other demonstrated ambulatory dysfunction. The injured worker has back pain that radiates to both arms and limited back motion. The pain was rated the same as last visit, which was 9.5/10 on pain scale. The objective findings revealed that the lying straight leg raise caused severe low back pain, there was poor tolerance to Gaenselen's test maneuver, and there was adaptive myofascial muscle shortening on the hamstring. The treating physician has not documented evidence of the above- referenced criteria. The criteria noted above not having been met, 1 Cane is not medically necessary.

1 Lumbar Brace: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disabilities Guidelines.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 301. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back - Lumbar & Thoracic (Acute & Chronic), Lumbar Supports.

Decision rationale: The requested 1 Lumbar Brace, is not medically necessary. American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004), Chapter 12, Low Back Complaints, Page 301, note "lumbar supports have not been shown to have any lasting benefit beyond the acute phase of symptom relief." Official Disability Guidelines (ODG), Low Back - Lumbar & Thoracic (Acute & Chronic), Lumbar Supports, also note Lumbar supports: Not recommended for prevention. Under study for treatment of nonspecific LBP. Recommended as an option for compression fractures and specific treatment of spondylolisthesis, documented instability, or post-operative treatment." The injured worker has back pain that radiates to both arms and limited back motion. The pain was rated the same as last visit, which was 9.5/10 on pain scale. The objective findings revealed that the lying straight leg raise caused severe low back pain, there was poor tolerance to Gaenselen's test maneuver, and there was adaptive myofascial muscle shortening on the hamstring. The treating physician has not documented the presence of spondylolisthesis, documented instability, or acute post-operative treatment. The criteria noted above not having been met, 1 Lumbar Brace is not medically necessary.

Container Of Compound Cream (Flurbiprofen 20% And Lidocaine 5%): Upheld

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

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

Decision rationale: The requested 1 Container Of Compound Cream (Flurbiprofen 20% And Lidocaine 5%), is not medically necessary. California Medical Treatment Utilization Schedule (MTUS), 2009, Chronic pain, page 111-113, Topical Analgesics, do not recommend topical analgesic creams as they are considered "highly experimental without proven efficacy and only recommended for the treatment of neuropathic pain after failed first-line therapy of antidepressants and anticonvulsants". The injured worker has back pain that radiates to both arms and limited back motion. The pain was rated the same as last visit, which was 9.5/10 on pain scale. The objective findings revealed that the lying straight leg raise caused severe low back pain, there was poor tolerance to Gaenselen's test maneuver, and there was adaptive myofascial muscle shortening on the hamstring. The treating physician has not documented trials of anti-depressants or anti-convulsants. The treating physician has not documented intolerance to similar medications taken on an oral basis, nor objective evidence of functional improvement from any previous use. The criteria noted above not having been met, 1 Container Of Compound Cream (Flurbiprofen 20% And Lidocaine 5%) is not medically necessary.

1 Container Of Compound Cream (Cyclobenzapine 10% And Lidocaine 2%) 4GM: Upheld

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

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

Decision rationale: The requested 1 Container Of Compound Cream (Cyclobenzapine 10% And Lidocaine 2%) 4gm is not medically necessary. California Medical Treatment Utilization Schedule (MTUS), 2009, Chronic pain, page 111-113, Topical Analgesics, do not recommend topical analgesic creams as they are considered "highly experimental without proven efficacy and only recommended for the treatment of neuropathic pain after failed first-line therapy of antidepressants and anticonvulsants". The injured worker has back pain that radiates to both arms and limited back motion. The pain was rated the same as last visit, which was 9.5/10 on pain scale. The objective findings revealed that the lying straight leg raise caused severe low back pain, there was poor tolerance to Gaenselen's test maneuver, and there was adaptive myofascial muscle shortening on the hamstring. The treating physician has not documented trials of anti-depressants or anti-convulsants. The treating physician has not documented intolerance to similar medications taken on an oral basis, nor objective evidence of functional improvement from any previous use. The criteria noted above not having been met, 1 Container Of Compound Cream (Cyclobenzapine 10% And Lidocaine 2%) 4gm is not medically necessary.