

<b>Case Number:</b>	CM13-0031433		
<b>Date Assigned:</b>	12/04/2013	<b>Date of Injury:</b>	08/26/2003
<b>Decision Date:</b>	01/22/2014	<b>UR Denial Date:</b>	09/25/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/03/2013

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Physical Medicine & Rehabilitation and Pain Medicine, and is licensed to practice in Texas. 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 physician 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 64 year old female who reported an injury on 08/26/2003. The mechanism of injury was a fall. The patient complained of pain to her low back which she rates constantly at a 6 on a scale of 1-10 with numbness and tingling to the foot. The patient was diagnosed with chronic lumbar radiculopathy with partial footdrop, multilevel disc herniations with moderate facet hypertrophy of the lumbar spine and status post microlumbar decompression in 2006. The clinical documentation submitted and dated 11/12/2013 states the patient had been treated with L4-5 laminectomy, chiropractic treatment, pain medication, nonsteroidal anti-inflammatory drugs (NSAIDs), epidural spinal injection (ESIs), and pain management. The patient continues to complain of low back pain and was recommended to use a transcutaneous electrical nerve stimulation (TENS) unit, medication, and chiropractic treatment.

### IMR ISSUES, DECISIONS AND RATIONALES

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

#### **#3 chiropractic with physiotherapy 2x4 (8):**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Section Manual Therapy and Manipulation.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Section Manual therapy and manipulation Page(s): 58.

**Decision rationale:** The CA MTUS Chronic Pain Medical Treatment guidelines recommend chiropractic care with a trial of 6 visits over a 2 week period, and a total of 18 visits over a 6-8 week period with evidence based objective functional improvement. The clinical documentation submitted for review does not show any symptomatic relief or functional improvement, such as a reduction in pain medication. The clinical documentation submitted for review states the patient continued to take her pain medication and muscle relaxants as she did prior to being treated by the chiropractor. Therefore, the request for additional chiropractic care is non-certified.

**Terocin pain patch Box 10 patches:** Upheld

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

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

**Decision rationale:** The CA MTUS Chronic Pain Medical Treatment guidelines state any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended and is primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. The use of these compounded agents requires knowledge of the specific analgesic effect of each agent and how it will be useful for the specific therapeutic goal required. Terocin contains a compound of lidocaine and menthol. The CA MTUS states Lidocaine topical analgesics are recommended for localized peripheral pain after there has been evidence of a trial of first-line therapy, such as gabapentin or Lyrica. The clinical documentation submitted does not indicate that the patient has undergone a trial of serotonin-norepinephrine reuptake inhibitors (SNRI) anti-depressants or an antiepileptic drug (AED) such as gabapentin or Lyrica. The CA MTUS Guidelines also state Lidoderm is the only FDA approved topical application of Lidocaine. Therefore, this request is non-certified.

**Orphenadrine Citrate (Norflex) 100mg, #60:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Section muscle relaxants..

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Section Muscle Relaxants Page(s): 63-65.

**Decision rationale:** The CA MTUS Chronic Pain Medical Treatment guidelines recommend non-sedating muscle relaxants with caution as a second-line option for short-term treatment and show no benefit in low back pain treatment. The clinical documentation submitted for review has not shown any objective findings to indicate that muscle relaxants have diminished the patient's pain as it is being prescribed for her low back pain. Therefore, this request is non-certified.

**TEN units trial x 30 days:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Section Transcutaneous electrical nerve stimulation (TENS)..

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Section Transcutaneous electrotherapy Page(s): 114.

**Decision rationale:** The CA MTUS Chronic Pain Medical Treatment guidelines do not recommended transcutaneous electrical nerve stimulation (TENS) as a primary treatment modality, but a one-month home-based TENS trial may be considered as a noninvasive conservative option, if used as an adjunct to a program of evidence-based functional restoration for evidence that other appropriate pain modalities have been tried and failed. The guidelines also state that one-month trial period of the TENS unit should be documented in adjunct to ongoing treatment modalities within a functional restoration approach. Other ongoing pain treatment should also be documented during the trial period including medication usage, specific short- and long-term goals of treatment with the TENS unit should be submitted. The clinical documentation submitted for review does not indicate if the patient will be participating in ongoing treatment modalities with a functional restorative approach, such as physical therapy. The documentation does not include any specific short- and long-term goals of treatment with the TENS unit as recommended by the guidelines. Therefore, this request is non-certified.