MAXIMUS Federal Services

Case Number:	CM13-0034651		
Date Assigned:	12/11/2013	Date of Injury:	01/24/2013
Decision Date:	02/18/2014	UR Denial Date:	09/30/2013
Priority:	Standard	Application Received:	10/15/2013

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 Familt Practice 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 32-year-old female who sustained a work-related injury on 01/24/2013. The patient's diagnoses include degenerative joint disease, disc protrusion, radiculopathy, lumbar pain, sciatica and a lumbar strain. Subjectively, the patient reported complaints of constant burning and/or aching thoracolumbar back pain, which she rated at an 8/10 with radiation into the left buttock and left posterior thigh. Objectively, the patient had a normal gait, negative straight leg raise, tenderness to palpation, intact motor strength, 2/2 deep tendon reflexes and intact sensation to pinprick and vibration. The patient reported improvement in pain with heat or ice, ibuprofen, stretching and lying down with the knees flexed. The patient was recommended to continue spinal exercises and utilize ibuprofen or Aleve on an as needed basis.

IMR ISSUES, DECISIONS AND RATIONALES

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

240gm compound of Capsaicin 0.025%/ Flurbiprofen 30%/ Methyl Salicylate 4%: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113, 121. Decision based on Non-MTUS Citation Official Disability Guidelines: Chapter Low Back, Web Edition.

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

Decision rationale: CA MTUS Guidelines indicate that "the only FDA approved NSAID agent for topical use is Voltaren Gel 1%...capsaicin is recommended only as an option in patients who have not responded or are intolerant to other treatments." Flurbiprofen is an NSAID that is not recommended for topical use per the guidelines or the FDA. Given that the guidelines indicate that if 1 of the medications in a compound is not recommended, then the compound as a whole cannot be recommended; the requested topical analgesic is not supported. Additionally, the clinical information submitted for review lacks objective documentation of medication efficacy to warrant the continued use. As such, the request for prescription 240 gm compound of capsaicin 0.025%/flurbiprofen 30%/methyl salicylate 4% is non-certified.

Medrox patch, #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113, 121. Decision based on Non-MTUS Citation Official Disability Guidelines: Chapter Low Back, Web Edition

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

Decision rationale: Medrox contains methyl salicylate 20%, menthol 5% and capsaicin 0.0375%. There have been no studies of a 0.0375% formulation of capsaicin, and there is no current indication that this increase over a 0.025% formulation would provide any further efficacy. Furthermore, guidelines also state that if 1 of the medications in a compound is not recommended that the topical compound as a whole cannot be recommended. Furthermore, the clinicals provided lacked objective documentation of the medication's efficacy to warrant further use. As such, the request for Medrox patches #30 is non-certified.

transcutaneous electrical nerve stimulator (TENS): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS Page(s): 114-116.

Decision rationale: The CA MTUS Guidelines state that TENS units are "not recommended 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 neuropathic pain, phantom limb pain and CRPS II, spasticity, and multiple sclerosis (MS)." The clinical information submitted for review indicates that the patient has a diagnosis of radiculopathy but lacks evidence to support a diagnosis of neuropathy, spasticity, CRPS or multiple sclerosis. As such, the requested service is not supported. Therefore, the request for the purchase of a transcutaneous electrical nerve stimulation (TENS) is non-certified.

Electrical muscle stimulator (EMS) purchase: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Neuromuscular electrical stimulator (NMES devices) Page(s): 121.

Decision rationale: The CA MTUS Guidelines state that NEMS is not recommended. "NMES is used primarily as part of a rehabilitation program following stroke, and there is no evidence to support its use in chronic pain. There are no intervention trials suggesting benefit from NMES for chronic pain." The clinicals provided indicate that the patient has lower back pain with radiculopathy. Given that there is no evidence to support the use of the requested service in patients with chronic pain, the request cannot be validated. As such, the request for an electrical muscle stimulator (EMS) purchase is non-certified.

Outpatient electrical shockwave therapy (ESWT) to the lumbar spine, quantity not indicated: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG states: Lumbar sprains and strains.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Wang, Ching-Jen. "Extracorporeal shockwave therapy in musculoskeletal disorders." Journal of orthopaedic surgery and research 7.1 (2012): 1-8.

Decision rationale: ACOEM Guidelines recommend extracorporeal shock wave therapy for calcifying tendinitis of the shoulder. "The application of extracorporeal shockwave therapy (ESWT) in musculoskeletal disorders has been around for more than a decade and is primarily used in the treatment of sports related over-use tendinopathies such as proximal plantar fasciitis of the heel, lateral epicondylitis of the elbow, calcific or non-calcific tendonitis of the shoulder and patellar tendinopathy etc." The clinicals provided lacked objective documentation of evidence to support the use of the requested service. The patient's diagnoses included degenerative joint disease, radiculopathy, low back pain, lumbar strain and disc herniation. The guidelines and literature do not support the use of the requested service in the aforementioned diagnoses. Furthermore, there is no quantity of sessions provided. Therefore, the request for outpatient electrical shockwave therapy (ESWT) to the lumbar spine, quantity not indicated, is non-certified.

Physical therapy 2 times per week for 6 weeks to the lumbar spine: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99.

Decision rationale: The CA MTUS Guidelines for Physical Medicine state that "active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort, and that patients are instructed in and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels." The clinicals provided indicate that the patient has undergone prior physical therapy, but there is a lack of objective documentation of significant functional improvement or a pain reduction. Further, there is a lack of documentation of exceptional factors to warrant additional formal physical therapy. The clinicals provided indicate that the patient was instructed in a home exercise program, and said program should be utilized to continue/maintain functional gains and pain reduction. Given the above, the request for physical therapy 2 times a week per week for 6 weeks to the lumbar spine is non-certified.