

<b>Case Number:</b>	CM13-0037143		
<b>Date Assigned:</b>	12/13/2013	<b>Date of Injury:</b>	11/16/2004
<b>Decision Date:</b>	07/31/2014	<b>UR Denial Date:</b>	10/14/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/23/2013

### 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 Family Medicine and is licensed to practice in Arizona. 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 60 year old male with a date of injury on 11/16/2004. The diagnoses include bilateral shoulder impingement, bilateral carpal tunnel syndrome, and chronic cervical, thoracic, and lumbosacral pain. The subjective complaints are of continued pain in the back, hips, knees and wrists. The physical exam shows spasm and tenderness in the lumbosacral paraspinal regions, worse on the left. There was also trigger points of pain over the superior and middle portion of the sacroiliac joints. Medications included Vicoprofen as needed and topical analgesics. The patient is also noted as using a traction interferential unit.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Continued Use of Transdermal Analgesic Ointment (Unspecified Type/ Dosage/Quantity) Quantity 1.00:** Upheld

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

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

**Decision rationale:** The CA Chronic Pain Guidelines are clear that if the medication contains one drug that is not recommended the entire product should not be recommended. The submitted

documentation does not identify the medications for the requested topical ointment. Therefore, the medical necessity of a topical analgesic is not established.

**Continued Use of Vicoprofen (Unspecified Dosage/Quantity) Quantity 1.00:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids chapter Page(s): 74-96.

**Decision rationale:** The patient in question has been on chronic opioid therapy. The CA Chronic Pain Guidelines has specific recommendations for the ongoing management of opioid therapy. Clear evidence should be presented about the degree of analgesia, level of activity of daily living, adverse side effects, or aberrant drug taking behavior. For this patient, no documentation is present of MTUS opioid compliance guidelines, including risk assessment, attempt at weaning, updated urine drug screen, and ongoing efficacy of medication. Furthermore, there is no demonstrated improvement in pain or function from long-term use. Therefore, the medical necessity for Vicoprofen is not established. As such, the request is not medically necessary.

**Continued Use of Home Lumbar Traction Inferential Unit (Unspecified Duration) Quantity 1.00:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Therapy chapter Page(s): 118-119.

**Decision rationale:** The CA MTUS does not recommend interferential current stimulation as an isolated intervention. But the CA MTUS does suggest it is possibly appropriate to have a one month trial if the following criteria are met, pain is ineffectively controlled due to diminished effectiveness of medications; pain is ineffectively controlled with medications due to side effects, or there is significant pain from postoperative or acute conditions that limits the ability to perform exercise programs/physical therapy treatment; or unresponsive to conservative measures. For this patient, there is no objective evidence submitted from a one-month trial. Furthermore, the records do not indicate that the patient was unresponsive to medication, and records did not identify other conservative measures that had been utilized. Therefore, the medical necessity of a lumbar traction interferential unit is not established at this time. As such, the request is not medically necessary.