

Case Number:	CM13-0040091		
Date Assigned:	12/20/2013	Date of Injury:	09/10/2008
Decision Date:	02/06/2014	UR Denial Date:	09/27/2013
Priority:	Standard	Application Received:	10/29/2013

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 and Rehabilitation and is licensed to practice in New York and 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 male who reported an injury on 09/10/2008. The mechanism of injury was not provided for review. The reported injury resulted in a low back injury. Prior treatments included radiofrequency neurotomies, epidural steroid injections, physical therapy, and medications. The patient's most recent clinical exam findings included bilateral facet joint tenderness to palpation at the L5-S1 level, restricted lumbar range of motion described as 60 degrees in flexion, 20 degrees in extension, 15 degrees in right and left lateral flexion, and 20 degrees in right and left rotation with paresthesia in the L4 dermatome. The patient's diagnoses included lumbar disc bulges, lumbar degenerative disc disease, lumbar spondylosis, right lumbar neuralgia, lumbar facet arthropathy, and opioid dependence. The patient's treatment plan included continued medication usage, chiropractic care, a TENS unit, and an additional radiofrequency rhizotomy.

IMR ISSUES, DECISIONS AND RATIONALES

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

Topical Cream: 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 Topical analgesics Page(s): 111.

Decision rationale: The requested topical cream is not medically necessary or appropriate. The clinical documentation submitted for review does not identify type, duration, or frequency of the requested topical cream. California Medical Treatment Utilization Schedule does not recommend the use of topical agents, as it is considered largely experimental and supported by few scientific studies. As the clinical information submitted for review does not provide any description of the topical cream requested, efficacy and safety cannot be established. As such, the requested topical cream is not medically necessary or appropriate.

Medication counseling: 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 Opioids On-Going Management, Page(s): 78. Decision based on Non-MTUS Citation Opioids On-Going Management, page(s)

Decision rationale: Official Disability Guidelines (ODG) Pain Chapter, Education.

request for CURES and UA: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids On-Going Management Page(s): 78.

Decision rationale: The requested CURES and UA are not medically necessary or appropriate. The clinical documentation submitted for review does provide evidence that the patient has been using opiates for an extended period of time. California Medical Treatment Utilization Schedule does recommend monitoring for aberrant behavior to include randomized urine drug screening. Although the requested urine analysis would be considered appropriate. The requested CURES is not specifically outlined within the documentation. There is no way to determine the appropriateness of this test or whether it would contribute to the patient's treatment plan. As the request is for a CURES and a UA, although a UA would be indicated, the request as it is written is not supported. As such, the requested CURES and UA is not medically necessary or appropriate.

TENS: Upheld

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

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

Decision rationale: The requested TENS unit is not medically necessary or appropriate. The clinical documentation submitted for review does provide evidence that the patient has chronic low back pain. California Medical Treatment Utilization Schedule recommends the use of a TENS unit be based on a 30 day clinical trial to support efficacy of this treatment modality. Additionally, the use of a TENS unit should be as an adjunct therapy to active therapy. The clinical documentation submitted for review does not provide any evidence that the patient has undergone a 30 day clinical trial to support the purchase of a TENS unit. Additionally, there is no documentation that the patient is currently participating in any type of active therapy to include a home exercise program. As such, the requested TENS unit is not medically necessary or appropriate