

<b>Case Number:</b>	CM13-0054440		
<b>Date Assigned:</b>	04/25/2014	<b>Date of Injury:</b>	09/26/1997
<b>Decision Date:</b>	08/15/2014	<b>UR Denial Date:</b>	11/13/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/19/2013

### 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 Physical Medicine and Rehabilitation, and is licensed to practice in California. 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 76 year-old male who has filed a claim for lumbar degenerative disc disease associated with an industrial injury date of September 26, 1997. A review of progress notes low back pain radiating to bilateral lower extremities up to the toes, more on the right. The findings include tenderness and decreased range of motion of the lumbar spine. Bilateral straight leg raise causes pain with questionable peroneal nerve stretch signs. The treatment to date has included NSAIDs, opioids, H-wave unit, lumbar epidural steroid injections, physical therapy, and acupuncture. A utilization review from November 13, 2013 denied the request for pain management follow-up with [REDACTED] as there is no quantification of the patient's response to the latest epidural steroid injection and findings do not show objective evidence of radiculopathy to support this follow-up for a repeat lumbar epidural steroid injection; acupuncture x 6 as previous acupuncture sessions did not provide functional benefit; Ketoprofen cream as this is not supported for topical use; and replacement patches for H-wave device as there is no documentation regarding frequency of use or specific functional benefits derived from this equipment.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**PAIN MANAGEMENT FOLLOW UP WITH [REDACTED]:** 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 Epidural Steroid Injection Page(s): 46. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain chapter, Office visits.

**Decision rationale:** The California MTUS does not address this topic. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, the ODG was used instead. ODG states that evaluation and management outpatient visits to the offices of medical doctor(s) play a critical role in the proper diagnosis and return to function of an injured worker, to monitor the patient's progress, and to make any necessary modifications to the treatment plan. As stated on page 46 of California MTUS Chronic Pain Medical Treatment Guidelines, there is no support for epidural injections in the absence of objective radiculopathy. Criteria for the use of epidural steroid injections include an imaging study documenting concordant nerve root pathology and conservative treatment. Repeat blocks should only be offered if there is at least 50% pain relief for six to eight weeks following previous injection, with a general recommendation of no more than 4 blocks per region per year. As per progress notes, the previous injection provided the patient numerous months of vastly reduced painful symptomatology. However, recent progress notes do not show clear evidence of objective radiculopathy. There is no quantification of pain relief from previous injections. Therefore, the request for pain management follow-up with [REDACTED] was not medically necessary.

**ACUPUNCTURE, EIGHT SESSIONS:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Acupuncture Treatment Guidelines. Decision based on Non-MTUS Citation Non-MTUS ACOEM Practice Guidelines, Chapter 6: Pain, Suffering, Restoration of Function, page 114.

**Decision rationale:** The California MTUS Acupuncture Medical Treatment Guidelines state that treatments may be extended if functional improvement is documented. In this case, patient has had previous acupuncture sessions in 2012 with functional improvement. There is no description of these sessions, or documentation of functional benefits derived. Also, the body part to which the acupuncture sessions are directed to is not specified. Therefore, the request for acupuncture x 8 was not medically necessary.

**KETOPROFEN CREAM:** Upheld

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

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

**Decision rationale:** As noted on page 111-113 of the California MTUS Chronic Pain Medical Treatment Guidelines, many agents are compounded as monotherapy or in combination for pain control. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Ketoprofen is not currently FDA-approved for topical application. It has an extremely high incidence of photocontact dermatitis. Patient has been on this medication since May 2013. However, this medication is not recommended for topical use. There is no discussion concerning the need for variance from the guidelines. Therefore, the request for Ketoprofen cream was not medically necessary.

**ULTRAM:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 78-81.

**Decision rationale:** As noted on page 78-81 of the California MTUS Chronic Pain Medical Treatment Guidelines, there is no support for ongoing opioid treatment unless there is ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. Patient has been on this medication since at least July 2013. There is no documentation regarding functional benefits, or periodic urine drug monitoring in this patient. The requested dosage and quantity is not specified. Previous utilization review determination, dated November 13, 2013, has already certified this request for #60. Therefore, the request for Ultram was not medically necessary.

**ANAPROX:** 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 Page(s): 67-69.

**Decision rationale:** As stated on pages 67-69 of the California MTUS Chronic Pain Medical Treatment Guidelines, NSAIDs are recommended at the lowest dose for the shortest period in patients with moderate to severe pain and there is no evidence of long-term effectiveness for pain or function. Patient has been on this medication since at least July 2013. Previous to that, NSAID therapy was discontinued and resulted in exacerbation of pain symptoms. Re-initiation of this medication brought the pain down to a tolerable level and increased the patient's flexibility. This medication is a reasonable option to manage the patient's pain symptoms. The requested quantity and dosage is not specified. Previous utilization review determination, dated November 13, 2013, has already certified this request for #60. Therefore, the request for Anaprox is not medically necessary.

**REPLACEMENT PATCHES FOR H-WAVE DEVICE:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 117-118.

**Decision rationale:** According to California MTUS Chronic Pain Medical Treatment Guidelines pages 117-118, H-wave therapy is not recommended as an isolated intervention, but a one-month home-based trial of H-Wave stimulation may be considered as a noninvasive conservative option for chronic soft tissue inflammation if used as an adjunct to a program of evidence-based functional restoration following failure of initially recommended conservative care, including recommended physical therapy, medications, and transcutaneous electrical nerve stimulation (TENS). In this case, there is no documentation regarding objective functional benefits derived from this equipment. There is also no documentation regarding the duration and frequency of use. There is no evidence of failure of conservative care as progress notes report that the pain medications help with the pain symptoms. Therefore, the request for replacement patches for H-wave was not medically necessary.