

<b>Case Number:</b>	CM13-0057159		
<b>Date Assigned:</b>	12/30/2013	<b>Date of Injury:</b>	04/13/2010
<b>Decision Date:</b>	05/22/2014	<b>UR Denial Date:</b>	11/18/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/25/2013

### 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 Occupational Medicine 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 applicant is a represented [REDACTED] employee who has filed a claim for chronic neck, low back, and midback pain reportedly associated with an industrial injury of April 13, 2010. Thus far, the applicant has been treated with the following: Analgesic medications; earlier cervical fusion surgery; attorney representation; unspecified amounts of physical therapy, and topical agents. In a Utilization Review Report of November 18, 2013, the claims administrator denied a request for an interferential unit, motorized cold therapy device, several topical compounds, and a urine toxicology screen. The applicant's attorney subsequently appealed. A clinical progress note of October 24, 2013 was notable for comments that the applicant was off of work, and on total temporary disability. The applicant did report persistent neck, midback, shoulder, and wrist pain with associated tenderness to touch and diminished range of motion noted about various body parts. A variety of treatments, including manipulative therapy, chiropractic treatment, and a motorized cold therapy device, topical compounds, and urine toxicology screening were requested through a request for authorization (RFA) form of November 13, 2013. No progress note or rationale was attached to the request for authorization. A later note of December 12, 2013 was again notable for comments that the applicant was off of work, and on total temporary disability. Again, no mention was made of the treatments requested through RFA forms.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**PURCHASE OF IF UNIT:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines INTERFERENTIAL CURRENT STIMULATION (ICS).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation (ICS) Page(s): 120.

**Decision rationale:** The Chronic Pain Medical Treatment Guidelines indicate that interferential current stimulation is tepidly endorsed on a one-month trial basis as an adjunct to return to work, exercise, and medications in applicants in whom there is evidence of diminished analgesic medication efficacy, history of substance abuse that would make the provision of analgesic medications unwise, evidence that pain is inadequately controlled owing to medication side effects, and/or evidence that an applicant has proven unresponsive to hot and cold therapy. In this case, however, there is no evidence that these criteria have been met. No rationale was attached to the request for authorization. No mention was made of this device on any recent progress note attached. There was no evidence that multiple classes of analgesic medications had been tried and/or failed. It was unclear why the device in question was being sought. Therefore, for all of the stated reasons, the request is not medically necessary.

**MOTORIZED COLD THERAPY DEVICE:** 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 ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 174.

**Decision rationale:** The MTUS/ACOEM Guidelines indicate that simple, low-tech applications of heat and cold are considered part and parcel of self-care and do represent methods of symptom control for neck and upper back complaints. While the ACOEM Guidelines endorse the usage of simple, low-tech applications of heat and cold, the Guidelines do not endorse delivery of cold therapy through high-tech means. In this case, as with the other request, the attending provider did not furnish any applicant-specific rationale, narrative, or commentary along with the request for authorization, which would offset the unfavorable guideline recommendations. Again, no mention was made of this device on any recent progress note. Therefore, the request is not medically necessary, on Independent Medical Review.

**PHARMACY PURCHASE OF BLURBIPROFEN 10%/CAPSACIN 0.025%/MENTHOL 2%/CAMPHOR 1%(120GM):** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment Page(s): 47,Chronic Pain Treatment Guidelines TOPICAL ANALGESICS Page(s): 111.

**Decision rationale:** The MTUS/ACOEM Guidelines indicate that oral pharmaceuticals are a first-line palliative method. In this case, there is no evidence of intolerance to and/or failure of multiple classes of first-line oral pharmaceuticals so as to make a case for topical agents and/or topical compounds, such as the flurbiprofen-containing agent in request. The Chronic Pain Guidelines indicate that topical analgesics are "largely experimental". Again, no applicant-specific information, narrative, or commentary was attached to the authorization, which would offset the unfavorable MTUS recommendations. No mention was made of this cream on any recent progress notes provided. Therefore, the request is likewise not medically necessary.

**PRESCRIPTION OF KETOPROFEN 10%/ CYCLOBENZAPRINE 3%/ LIDOCAINE 5% (120GM):** Upheld

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

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

**Decision rationale:** The Chronic Pain Medical Treatment Guidelines indicate that neither ketoprofen nor cyclobenzaprine are recommended for topical compound formulation purposes. The Guidelines also indicate that any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Since one or more ingredients in the compound carry unfavorable recommendations, the entire compound is considered not recommended. Therefore, the request is likewise not medically necessary.

**URINALYSIS TEST FOR TOXICOLOGY EXAM:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG)

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines DRUG TESTING Page(s): 43. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG), CHRONIC PAIN CHAPTER, URINE DRUG TESTING

**Decision rationale:** The Chronic Pain Medical Treatment Guidelines does support intermittent drug testing in the chronic pain population; however, the Guidelines do not establish specific parameters for or identify a frequency with which to perform drug testing. The Official Disability Guidelines indicate that it is incumbent upon the attending provider to furnish an applicant's complete medication list along with the request for authorization for drug testing. The attending provider should also furnish a list of those drug tests and/or drug panels, which he/she intends to test for along with the request for authorization. In this case, however, the

attending provider did not furnish any applicant-specific rationale, narrative, or commentary along with the request for authorization so as to make a case for the drug test in question. Therefore, the request is likewise not medically necessary, on Independent Medical Review.