

<b>Case Number:</b>	CM13-0057806		
<b>Date Assigned:</b>	12/30/2013	<b>Date of Injury:</b>	07/14/2011
<b>Decision Date:</b>	05/02/2014	<b>UR Denial Date:</b>	11/15/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/26/2013

### 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 Anesthesiology, has a subspecialty in Pain Management and is licensed to practice in Florida. 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 50-year-old male who reported an injury on 07/14/2011. The mechanism of injury was not provided. The patient is currently diagnosed with bilateral lumbar radiculopathy and herniated nucleus pulposus at L4-5 and L5-S1. The patient was evaluated on 09/06/2013. The patient reported 9/10 neck, mid back and low back pain. The patient is currently utilizing a TENS unit. Physical examination revealed limited lumbar range of motion, tenderness to palpation, intact sensation, and diminished strength on the left. Treatment recommendations at that time included a transforaminal epidural steroid injection, aquatic therapy, and continuation of current medications.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**TEROCIN PATCH #10:** Upheld

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

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

**Decision rationale:** The California MTUS Guidelines state topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety.

Capsaicin is recommended only as an option in patients who have not responded or are intolerant to other treatments. Lidocaine is indicated for neuropathic or localized peripheral pain after there has been evidence of a trial of first-line therapy. As per the documentation submitted, the patient has utilized Terocin topical analgesics since 06/2013. There is no evidence of objective functional improvement. There is also no indication of a failure to respond to first-line oral medication prior to the initiation of a topical analgesic. Based on the clinical information received and the California MTUS Guidelines, the request is non-certified.

**WATER THERAPY X8:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 22.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Aquatic Therapy Page(s): 22.

**Decision rationale:** The California MTUS Guidelines state aquatic therapy is recommended as an optional form of exercise therapy, where available as an alternative to land-based physical therapy. As per the documentation submitted, there is no indication that this patient requires reduced weightbearing as opposed to land-based physical therapy. Therefore, the current request cannot be determined as medically appropriate. As such, the request is non-certified.

**ADDITIONAL CHIROPRACTIC TREATMENT FOR THE BACK X8:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 58.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy & Manipulation Page(s): 58.

**Decision rationale:** The California MTUS Guidelines state manual therapy and manipulation are recommended if caused by a musculoskeletal condition. Treatment for the low back is recommended as an option with a therapeutic trial of 6 visits over 2 weeks. With evidence of objective functional improvement, a total of up to 18 visits over 6 to 8 weeks may be appropriate. There is no documentation of a previous course of chiropractic therapy. Without evidence of objective functional improvement, additional therapy cannot be determined as medically appropriate. Therefore, the request is non-certified.

**TRIAL TENS UNIT X30 DAYS:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 117-121.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous Electrotherapy Page(s): 117-121.

**Decision rationale:** The California MTUS Guidelines state transcutaneous electrotherapy is not recommended as a primary treatment modality, but a 1 month home-based trial may be considered as a noninvasive conservative option. As per the documentation submitted, the patient was issued a TENS unit in 06/2013. It was also noted on 09/06/2013 the patient's TENS unit had recently been replaced. There is no documentation of how often the unit used as well as outcomes in terms of pain relief and function. Therefore, ongoing treatment cannot be determined as medically appropriate. As such, the request is non-certified.