

<b>Case Number:</b>	CM14-0004919		
<b>Date Assigned:</b>	05/23/2014	<b>Date of Injury:</b>	01/21/1997
<b>Decision Date:</b>	07/28/2014	<b>UR Denial Date:</b>	01/02/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/14/2014

### 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 patient is a 31-year-old male who has submitted a claim for lumbar radiculopathy associated with an industrial injury date of 01/21/1997. Medical records from 07/30/2013 to 01/07/2014 were reviewed and showed that patient complained of low back pain graded 5-6/10. Physical examination revealed a limp gait with bilateral tenderness and spasms of the L3-5 and L5-S1 paraspinal muscles. There was tenderness to palpation over the bilateral SI joints. Lumbar spine ROM (range of motion) was decreased. FABER sign was positive. Sensation was decreased over the left lateral and right posterior aspect of the lower extremities. MRI of the lumbar spine dated 04/11/2014 revealed multilevel degenerative disc changes along L2-5, mild spinal stenosis L2-4 and L2-3 disc bulge measuring 1.5mm. Treatment to date has included physical therapy, acupuncture, Home Exercise program, pain medications, and Ketoprofen cream. Utilization review, dated 01/02/2014, denied the request for prescription of Ketoprofen cream 20% and 1 month-trial rental of H-wave machine for the lumbar spine. The rationale for both decisions was not attached with the medical records.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Prescription of ketoprofen cream 20%, (prescribed on 12/10/13): 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): 111-112.

**Decision rationale:** As stated on pages 111-112 of the California MTUS Chronic Pain Medical Treatment Guidelines, Ketoprofen is not recommended for topical use as there is a high incidence of photo contact dermatitis. Topical analgesics are largely experimental in use with few randomized controlled trials to determine safety or efficacy. In this case, the patient was prescribed Ketoprofen cream 20% since 12/10/2013. There was no documentation of intolerance to oral medications. The guidelines clearly state that a topical analgesic containing an ingredient that is not recommended is not recommended. Therefore, the request for prescription of Ketoprofen 20% cream is not medically necessary.

**1 month trial rental of a h-wave machine, for the lumbar spine:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines H-Wave Stimulation (HWT).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines H-wave Stimulation Page(s): 117-120.

**Decision rationale:** According to pages 117-120 of CA MTUS Chronic Pain Treatment Guidelines, H-Wave stimulation is not recommended as a primary treatment modality, but a one-month home-based H-Wave stimulation trial may be considered as a noninvasive conservative option for diabetic neuropathic pain or chronic soft tissue inflammation, if used as an adjunct to a program of evidence-based functional restoration and only following failure of initially recommended conservative care, including recommended physical therapy (i.e., exercise) and medications, plus transcutaneous electrical nerve stimulation (TENS). A one-month trial period of the H-wave stimulation unit should be documented (as an adjunct to ongoing treatment modalities within a functional restoration approach) with documentation of how often the unit was used, as well as outcomes in terms of pain relief and function. In this case, there was no documentation of previous physical therapy and TENS unit outcome. There was no documentation of active participation in a functional restoration program by the patient or evidence of acute exacerbation. It is unclear as to why H-wave therapy is needed. Therefore, the request for 1 Month Trial Rental Of A H-Wave Machine, For The Lumbar Spine is not medically necessary.