

<b>Case Number:</b>	CM14-0018705		
<b>Date Assigned:</b>	04/18/2014	<b>Date of Injury:</b>	06/07/2007
<b>Decision Date:</b>	07/09/2014	<b>UR Denial Date:</b>	02/10/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/13/2014

### 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 Physical Medicine & 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 injured worker is a 60-year-old male who reported injury on 06/07/2007. The mechanism of injury was cumulative trauma. There was no PR-2 nor DWC Form RFA submitted with this request. The diagnosis was lumbar spine sprain and strain. Per the submitted request, a request was made for an interferential stimulation device purchase, supplies, Ultram, Zanaflex, Neurontin, and Dendracin topical lotion.

### IMR ISSUES, DECISIONS AND RATIONALES

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

#### **INTERFERENTIAL STIMULATION DEVICE, PURCHASE: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulator Page(s): 118.

**Decision rationale:** The California MTUS Guidelines do not recommend interferential current stimulation as an isolated intervention. There was no PR-2 nor DWC form RFA submitted to support this request. As such there was no documentation of the duration of trial usage and the injured worker's response to the treatment as well as no documentation indicating the unit would

not be used as an isolated intervention. Given the above, the request for interferential stimulation device purchase is not medically necessary.

**SUPPLIES X 3-6 MONTHS: ELECTRODES #24, POWER PACK #72, ADHESIVE REMOVER TOWEL #96: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**ULTRAM 50MG, #120: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Medications for Chronic pain, ongoing management Page(s): 60, 78.

**Decision rationale:** The California MTUS Guidelines recommend opiates for the treatment of chronic pain. There should be documentation of objective functional improvement, an objective decrease in pain, and documentation the injured worker is being monitored for aberrant drug behavior and side effects. There was no PR-2 nor DWC form RFA submitted to support this request. The duration of use could not be established through the submitted documentation. The request as submitted failed to indicate the frequency for the requested medication. Given the above, the request for Ultram 50 mg #120 is not medically necessary.

**ZANAFLEX 4MG, #90: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines MUSCLE RELAXANTS Page(s): 63, 65.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants Page(s): 63.

**Decision rationale:** The California MTUS Guidelines recommend muscle relaxants as a second-line treatment of acute low back pain, and their use is recommended for less than 3 weeks. There should be documentation of objective functional improvement. There was no PR-2 nor DWC form RFA submitted to support this request. The duration of use could not be established through the submitted documentation. There was no documentation of spasms, that this was acute low back pain and a necessity for 90 tablets. The request as submitted failed to indicate the frequency for the requested medication. Given the above, the request for Zanaflex 4 mg #90 is not medically necessary.

**NEURONTIN 300MG, #30: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 49.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Antiepileptic Drug Page(s): 16.

**Decision rationale:** The California MTUS Guidelines recommend antiepileptic medications as a first-line medication for treatment of neuropathic pain. There should be documentation of an objective decrease in pain and objective functional improvement. There was no PR-2 nor DWC form RFA submitted to support this request. The duration of use could not be established through the submitted documentation. As such, there was no documentation of neuropathic pain and that there was an objective decrease in pain and objective functional improvement. The request as submitted failed to indicate the frequency for the requested medication. Given the above, the request for Neurontin 300 mg #30 is not medically necessary.

**DENDRACIN TOPICAL LOTION 120ML: 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 Salicylates, Topical Analgesics, Lidoderm Page(s): 105, 111, 112.

**Decision rationale:** The California MTUS indicates that Topical Salicylates are recommended and topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. They are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Benzocaine is similar to Lidocaine and Lidocaine is only recommended in a Lidoderm patch. Per the online drug insert, Dendracin includes Methyl Salicylate, Benzocaine and Menthol and it is used for: Temporary relief of minor aches and pains caused by arthritis, simple backache, and strains. There was no PR-2 nor DWC form RFA submitted to support this request. The duration of use could not be established through the submitted documentation. As such, there was no documentation of a trial and failure of antidepressants and anticonvulsants. There was no documentation of exceptional factors to warrant non-adherence to guideline recommendations. The request as submitted failed to indicate the frequency for the requested medication. Given the above, the request for Dendracin topical lotion 120 ml is not medically necessary.