

<b>Case Number:</b>	CM14-0029167		
<b>Date Assigned:</b>	06/20/2014	<b>Date of Injury:</b>	01/18/2008
<b>Decision Date:</b>	07/17/2014	<b>UR Denial Date:</b>	02/26/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/07/2014

### 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 and Rehabilitation and is licensed to practice in Illinois. 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 54-year-old male who reported an injury on 01/18/2008. Mechanism of injury is unknown. The injured worker complained of lower back pain and right knee pain. Stated the pain to be moderate and frequent. The injured worker also complained of joint pain with muscle spasms. No measurable pain noted. Physical Examination showed flexion of the right knee to be 134/150. The injured worker ambulated with a cane. The injured worker has diagnoses of right knee sprain, lumbar sprain and hemiparesis/weakness. The injured worker was treated with acupuncture, 2 times a week for 3 weeks. There is a lack of documentation as to current conservative care, range of motion, strength, measurable pain and functional deficits. The treatment plan is for an OS4 Unit for home use. The rationale was not submitted for review. The request for authorization form was submitted on 10/30/2013 by [REDACTED]

### IMR ISSUES, DECISIONS AND RATIONALES

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

**OS4 Unit for home use.:** 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 Guidelines Transcutaneous electrotherapy, page(s) 114-116 Page(s): 114-116.

**Decision rationale:** The MTUS Chronic Pain Guidelines state that OS4 units are not recommended as a primary treatment modality, but a one-month home-based trial may be considered as a noninvasive conservative option, if used as an adjunct to a program of evidence-based functional restoration. Several published evidence-based assessments have found that evidence is lacking concerning effectiveness of OS units. The MTUS Chronic Pain Guidelines stipulate the following: Documentation of pain of at least three months duration. There is evidence that other appropriate pain modalities have been tried (including medication) and failed. Other ongoing pain treatment should also be documented including medication usage. The reports submitted for review lack any evidence of medications and/or conservative care treatment. There was also no documentation of physical findings to determine functional deficits of the injured worker. Furthermore, there was no evidence showing that the injured worker was unsuccessful with conservative care. As such, the request is not medically necessary and appropriate.

**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 Analgesics Page(s): 111-113.

**Decision rationale:** The MTUS Chronic Pain Guidelines state that any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. The efficacy in clinical trials for this treatment modality has been inconsistent and most studies are small and of short duration. Dendracin is a compounded topical cream containing Methyl Salicylate 30%, Capsaicin 0.0375% and Menthol USP 10%. There have been no studies of a 0.0375% formulation of capsaicin and there is no current indication that this increase over a 0.025% formulation would provide any further efficacy. Furthermore, the MTUS Chronic Pain Guidelines state that a topical such as Dendracin should only be recommended after documented trials of antidepressants and anticonvulsants have failed. There is no evidence in submitted reports indicating that the injured worker has done so. There was also no evidence of failed conservative care. As such, the request is not medically necessary and appropriate.