

Case Number:	CM14-0039704		
Date Assigned:	06/27/2014	Date of Injury:	07/22/2009
Decision Date:	08/25/2014	UR Denial Date:	04/01/2014
Priority:	Standard	Application Received:	04/03/2014

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 Anesthesia, has a subspecialty in Acupuncture and Pain 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 51y/o male injured worker is with date of injury 7/22/09 with related pain and stiffness in his cervical spine and lumbar spine with pain radiating down both arms and legs. Per progress note dated 2/28/14, he also reported pain in both knees. Per physical exam of the cervical spine, tenderness to palpation over the paraspinal musculature with spasms was noted. Examination of the lumbar spine revealed tenderness to palpation over the paraspinal musculature, with muscle spasms present. There was referred pain to both buttocks and lower extremities. Straight leg raise test was positive bilaterally. Reflexes and sensations were decreased in the lower extremities. Imaging studies were not available in the documentation submitted for review. Treatment to date has included injections, physical therapy, and medication management. The date of UR decision was 4/1/14.

IMR ISSUES, DECISIONS AND RATIONALES

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

Flurbiprofen compound topical ointment, Ketoprofen Compound Cream: 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): 60, 111-113.

Decision rationale: Per MTUS with regard to Flurbiprofen (page 112) (Biswal, 2006) these medications may be useful for chronic musculoskeletal pain, but there are no long-term studies of their effectiveness or safety. Flurbiprofen may be indicated. With regard to topical Ketoprofen, the MTUS CPMTG states that this agent is not currently FDA approved for a topical application. It has an extremely high incidence of photo contact dermatitis. (Diaz, 2006) (Hindsen, 2006) Regarding the use of multiple medications, MTUS page 60 states that only one medication should be given at a time and interventions that are active and passive should remain unchanged at the time of the medication change. A trial should be given for each individual medication. Analgesic medications should show effects within 1 to 3 days, and the analgesic effect of antidepressants should occur within 1 week. A record of pain and function with the medication should be recorded. (Mens, 2005) The recent AHRQ review of comparative effectiveness and safety of analgesics for osteoarthritis concluded that each of the analgesics was associated with a unique set of benefits and risks, and no currently available analgesic was identified as offering a clear overall advantage compared with the others. Therefore, it would be optimal to trial each medication individually. Note the statement on page 111: Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. As Ketoprofen is not recommended, the request is not medically necessary.

TENS Unit Round Pads Refill: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous Electrical Nerve Stimulation.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TRANSCUTANEOUS ELECTROTHERAPY Page(s): 114-116.

Decision rationale: Per MTUS CPMTG, "TENS is not recommended as a primary treatment modality, but a one-month home-based TENS trial may be considered as a noninvasive conservative option, if used as an adjunct to a program of evidence-based functional restoration. While TENS may reflect the long-standing accepted standard of care within many medical communities, the results of studies are inconclusive; the published trials do not provide information on the stimulation parameters which are most likely to provide optimum pain relief, nor do they answer questions about long-term effectiveness." The California MTUS specifies the following criteria for use of TENS: documentation of pain for at least three months duration; documented evidence of the failure of other appropriate pain modalities; a documented one-month trial period of the TENS unit with outcomes of pain relief and/or increased function; documentation of other ongoing pain treatment during the trial period including medication usage; a treatment plan including the specific short- and long-term goals of treatment with the TENS unit. The submitted documentation does not contain sufficient descriptive criteria as required by the California MTUS to establish the medical necessity of a TENS unit. The documentation submitted for review does not describe outcomes of pain relief and/or increased function, the failure of other appropriate pain modalities, or include a treatment plan. As the use of TENS unit is not supported, the request for TENS unit refill pads is not medically necessary.

