

Case Number:	CM14-0043426		
Date Assigned:	08/08/2014	Date of Injury:	02/11/2010
Decision Date:	09/11/2014	UR Denial Date:	03/10/2014
Priority:	Standard	Application Received:	03/17/2014

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 Preventive Medicine, and is licensed to practice in Indiana. 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:

This employee is a 54 year old male with date of injury of 2/11/2010. A review of the medical records indicates that the patient is undergoing treatment for lumbago. Subjective complaints include continued low back pain. Objective findings include limited range of motion of cervical and lumbar spine and tenderness upon palpation of lumbar spine. Treatment has included lumbar epidural steroid injection, back brace, chiropractic and physical therapy, acupuncture, Fluriflex, Medrox patch, Tramadol, Flexeril, and Carisoprodol. The utilization review dated 3/10/2014 non-certified an interferential unit, thermophore heat pads, home exercise kit, back support, Fluriflex, and TG hot topical.

IMR ISSUES, DECISIONS AND RATIONALES

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

INTERFERENTIAL UNIT QTY: 1: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines IF Unit.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 287-315, Chronic Pain Treatment Guidelines Current Stimulation, Transcutaneous electrotherapy Page(s): page(s) 54, 114-116, 118-120.

Decision rationale: ACOEM guidelines state insufficient evidence exists to determine the effectiveness of sympathetic therapy, a noninvasive treatment involving electrical stimulation, also known as interferential therapy. At-home local applications of heat or cold are as effective as those performed by therapists. MTUS further states, not recommended as an isolated intervention and details the criteria for selection, Pain is ineffectively controlled due to diminished effectiveness of medications, or pain is ineffectively controlled with medications due to side effects; or history of substance abuse; or significant pain from postoperative conditions limits the ability to perform exercise programs/ physical therapy treatment; or unresponsive to conservative measures (e.g., repositioning, heat/ice, etc.). If those criteria are met, then a one-month trial may be appropriate to permit the physician and physical medicine provider to study the effects and benefits. The treating physician's progress notes do not indicate that the patient has poorly controlled pain, concerns for substance abuse, pain from postoperative conditions that limit ability to participate in exercise programs/treatments, or is unresponsive to conservative measures. The request for an interferential unit is not medically necessary based on MTUS guidelines.

THERMOPHORE MOIST HEAT PAD (REFILLS) QTY: 1: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 264.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 173-174. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck and Upper Back (Acute & Chronic), Heat/cold applications.

Decision rationale: Thermophore is a commercially available electronic heating pad with various heat settings. ACOEM and ODG comment on heat/cold packs, Recommended. Insufficient testing exists to determine the effectiveness (if any) of heat/cold applications in treating mechanical neck disorders, though due to the relative ease and lack of adverse effects, local applications of cold packs may be applied during first few days of symptoms followed by applications of heat packs to suit patient. There is no evidence to specifically recommend electronically controlled heating pads. The guidelines to appear to recommend short term use of heat application, but does further state that the evidence is supportive. With a date of injury of 2010, the patient is significantly past the 'acute' phase of the injury. As such, the request for one Thermophore Moist Heating Pad is not medically necessary.

HOME EXERCISE KIT QTY: 1: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 203.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Home exercise Page(s): 46-47.

Decision rationale: Chronic Pain Medical Treatment guidelines indicate there is no evidence to support the recommendation of any one particular exercise program over another. Home

exercises emphasizing education and independence are endorsed as quickly as practicable. In this case, it is not clearly stated why the employee needs specialized equipment and/or is incapable of participating in a home exercise program. It is not clearly stated what the home exercise kit represents and/or which body part and/or diagnoses it is intended to serve. The request for a home exercise kit is not medically necessary and appropriate.

BACK SUPPORT QTY: 1: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 298.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): page 301. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back (Lumbar and Thoracic), Lumbar Support.

Decision rationale: ACOEM states, Lumbar supports have not been shown to have any lasting benefit beyond the acute phase of symptom relief. ODG states, not recommended for prevention. Recommended as an option for treatment. See below for indications. Prevention: Not recommended for prevention. There is strong and consistent evidence that lumbar supports were not effective in preventing neck and back pain. (Jellema-Cochrane, 2001) (Van Poppel, 1997) (Linton, 2001) (Assendelft-Cochrane, 2004) (van Poppel, 2004) (Resnick, 2005) Lumbar supports do not prevent LBP. (Kinkade, 2007) A systematic review on preventing episodes of back problems found strong, consistent evidence that exercise interventions are effective and other interventions not effective, including stress management, shoe inserts, back supports, ergonomic/back education, and reduced lifting programs. (Bigos, 2009) This systematic review concluded that there is moderate evidence that lumbar supports are no more effective than doing nothing in preventing low-back pain. (Van Duijvenbode, 2008). ODG states for use as a treatment: Recommended as an option for compression fractures and specific treatment of spondylolisthesis, documented instability, and for treatment of nonspecific LBP (very low-quality evidence, but may be a conservative option). The patient is beyond the acute phase of treatment and the treating physician has provided no documentation of spondylolisthesis or documented instability. As such the request for back support is not medically necessary.

Fluriflex Qty 1: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines topical analgesics Page(s): 111-113.

Decision rationale: The MTUS Chronic Pain guidelines note that any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. The guidelines further note that baclofen and other muscle relaxants are not recommended as a topical product. The muscle relaxant cyclobenzaprine component of the topical Fluriflex is not

recommended, so the Fluriflex is not recommended. The requested Fluriflex cream is not medically necessary and appropriate.

Topical Guide Hot topical refill Qty 1: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines topical analgesics Page(s): 111-113.

Decision rationale: Chronic Pain Medical Treatment Guidelines state topical analgesics are recommended as an option for treatment, but are largely experimental in use and primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. As per the clinical information received for this review, there is no documented evidence of a diagnosis including neuropathic pain. There is also no evidence of a trial of antidepressants and anticonvulsants that have failed. California Guidelines further state any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. NSAIDs are recommended for short-term duration of treatment for osteoarthritis. Recommended use includes 4 to 12 weeks. The only FDA- approved NSAID medication for topical use includes diclofenac which is indicated for relief of osteoarthritis pain in joints that lend themselves to a topical treatment, including ankle, elbow, foot, hand, knee, and wrist. Capsaicin is recommended only as an option in patients who have not responded or are intolerant to other treatments. Indications include osteoarthritis, fibromyalgia, and chronic non- specific back pain. Gabapentin is not recommended for topical use and there is no evidence for the use of any other antiepilepsy drug as a topical product as well. There was also no evidence for use of any muscle relaxant as a topical product. As per the clinical notes submitted, the employee is well beyond the recommended use of a topical NSAID including 4 to 12 weeks duration. The request for TG Hot (Tramadol /Gabapentin /Menthol /Camphor /Capsaicin 8/10/2/.5%) is not medically necessary.