

Case Number:	CM14-0064247		
Date Assigned:	07/11/2014	Date of Injury:	02/19/2004
Decision Date:	09/15/2014	UR Denial Date:	04/15/2014
Priority:	Standard	Application Received:	05/07/2014

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 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:

This is a 58-year-old female with a 2/19/04 date of injury. The patient was asked to lift and carry boxes of weapons weighing approximately 30-40 pounds when he experienced a sharp shooting pain in his back. According to a 4/11/14 progress report, the patient complained of back pain. Objective findings include: antalgic gait, lumbar spine tenderness to palpation bilateral paraspinal muscles, sacroiliac joints, sciatic notch, posterior iliac crests, gluteal muscles; spasms bilateral paraspinal muscles, gluteal muscles; palpable trigger points bilateral paraspinal muscles; decreased ROM. Diagnostic impression: lumbosacral musculoligamentous strain/sprain with radiculitis, rule out lumbosacral spine discogenic disease. Treatment to date includes: medication management and activity modification. A Utilization Review decision dated 4/15/14 denied the requests for Terocin patches, 1 interferential unit, and 1 cold/hot unit. Regarding Terocin patches, according to submitted medical records, the patient was not suffering from neuropathic pain, nor did he fail a trial of first-line drugs. Regarding interferential unit, based on the lack of guideline support for this type of treatment and subjective and objective findings, this request is non-certified. Regarding a hot/cold unit, based on the lack of guideline support for this type of treatment, as well as the lack of special circumstances that would warrant this type of treatment, this request is non-certified.

IMR ISSUES, DECISIONS AND RATIONALES

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

Terocin patches #60 ([REDACTED]): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 112. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence:<http://dailymed.nlm.nih.gov/dailymed/lookup.cfm?setid=100ceb76-8ebe-437b-a8de-37cc76ece9bb>.

Decision rationale: The Expert Reviewer based his/her decision on the MTUS Chronic Pain Medical Treatment Guidelines, page 112 and on the Non-MTUS Other Medical Treatment Guideline or Medical Evidence:

<http://dailymed.nlm.nih.gov/dailymed/lookup.cfm?setid=100ceb76-8ebe-437b-a8de-37cc76ece9bb>. The Expert Reviewer's decision rationale: MTUS chronic pain medical treatment guidelines states that "topical Lidocaine in the formulation of a dermal patch has been designated for orphan status by the FDA for neuropathic pain." In addition, CA MTUS states that "topical Lidocaine may be recommended for localized peripheral pain after there has been evidence of a trial of first-line therapy (tri-cyclic or SNRI anti-depressants or an AED such as gabapentin or Lyrica)." The guidelines state that for "continued use of Terocin patches, the area for treatment should be designated as well as number of planned patches and duration for use (number of hours per day). There should be documentation of a successful trial of Terocin patches, as well as a discussion of functional improvement, including the ability to decrease the patient's oral pain medications." The documentation provided does not provide this information. In addition, there is no discussion in the reports regarding the patient failing treatment with a first-line agent such as gabapentin. Therefore, the request for Terocin patches #60 () was not medically necessary.

Interferential unit (): Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 171.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 118-120.

Decision rationale: The Expert Reviewer based his/her decision on the MTUS Chronic Pain Medical Treatment Guidelines, page 118-120. The Expert Reviewer's decision rationale: Chronic Pain Medical Treatment Guidelines state that "a one-month trial may be appropriate when 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." According to the reports reviewed, there is no documentation that the patient has failed conservative therapy modalities. In fact, according to the most recent progress report reviewed, dated 4/11/14, the provider is requesting chiropractic treatment. Therefore, the request for Interferential unit () was not medically necessary.

1 cold/hot unit ([REDACTED]): Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation X Other Medical Treatment Guideline or Medical Evidence: Aetna Clinical Policy Bulletin: Cryoanalgesia and Therapeutic Cold.

Decision rationale: The Expert Reviewer based his/her decision on the Non-MTUS X Other Medical Treatment Guideline or Medical Evidence: Aetna Clinical Policy Bulletin: Cryoanalgesia and Therapeutic Cold. The Expert Reviewer's decision rationale: Aetna considers the use of the "Hot/Ice Machine and similar devices (e.g., the Hot/Ice Thermal Blanket, the TEC Thermoelectric Cooling System (an iceless cold compression device), the Vital Wear Cold/Hot Wrap, and the Vital Wrap) experimental and investigational for reducing pain and swelling after surgery or injury." Studies in the published literature have been poorly designed and have failed to show that the Hot/Ice Machine offers any benefit over standard cryotherapy with ice bags/packs; and there are no studies evaluating its use as a heat source. There is no documentation that the patient has tried using ice/heat bags for his pain. A specific rationale identifying why a hot/cold unit was required in this patient despite lack of guideline support was not provided. Therefore, the request for 1 cold/hot unit ([REDACTED]) was not medically necessary.