

Case Number:	CM14-0174322		
Date Assigned:	12/15/2014	Date of Injury:	05/02/2014
Decision Date:	01/21/2015	UR Denial Date:	09/16/2014
Priority:	Standard	Application Received:	10/21/2014

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, has a subspecialty in Interventional Spine 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 patient is a 41 year old male with an injury date of 05/02/14. The patient is status post bilateral laminotomies, foraminotomies, medial facetectomy and discectomy at L4-5 with decompression of neural elements, as per operative report dated 11/18/14 (after the UR date). Based on the progress report dated 09/03/14, the patient complains of pain in neck, back and bilateral extremities rated at 8/10. Physical examination reveals tenderness in all the affected areas along spasms in the neck and back. Physical examination, as per progress report dated 08/27/14, reveals positive compression test and reduced range of motion in the cervical spine. There are spasms and trigger points along with tenderness in the mid and lower thoracic region bilaterally. Straight leg raise is positive. Physical examination, as per progress report dated 08/14/14, reveals decreased sensation to light touch in innerspace R Foot 1-2 toes and plantar surface. Medications, as per progress report dated 08/27/14, include Norco, Cyclobenzaprine, and Methoderm gel. The patient also received a lumbosacral brace for managing symptoms. The patient's work status has been determined as totally and temporarily disabled, as per progress report dated 08/27/14. MRI of the Lumbar Spine (no date provided), as per progress report dated 08/14/14:- Large posterior disc extrusion of L4-5- Severe central canal stenosis and mild bilateral neural foraminal narrowing- Small anterior disc osteophyte complex Diagnoses, 09/03/14:- Cervical spine strain / sprain with radiculitis, R/O cervical discogenic disease- Thoracic spine strain/ sprain- Lumbar spine strain / sprain with radiculitis, R/O lumbar discogenic disease- Bilateral shoulder impingement syndrome- Bilateral elbow strain/ sprain- Bilateral elbow lateral epicondylitis- Bilateral wrist strain/ sprain, R/O Bilateral wrist carpal tunnel syndrome- Bilateral wrist chronic overuse syndrome- Depression, situational- Sleep disturbance, secondary to pain The treatee is requesting for (a) Prospective request for 1 IF Unit

(b) Prospective request for 1 Hot and Cold Unit (c) 1 Prescription of Mentherm Gel 240 gm. The utilization review determination being challenged is dated 09/16/14. The rationale follows: The rationale follows:(a) Prospective request for 1 IF unit - There is no evidence of ineffective pain control, limited ability to perform exercise program, substance abuse, or side effects from medications.(b) Prospective request for 1 Hot and Cold Unit - "Guidelines do not support or provide evidence based guidance for continuous flow cryo or heat therapy for the spine." (c) 1 Prescription of Mentherm Gel 240 gm the guidelines clearly do not support the use of methyl salicylate for the spine." Efficacy of menthol has not been established as well. Treatment reports were provided from 07/23/14 - 12/03/14.

IMR ISSUES, DECISIONS AND RATIONALES

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

Prospective request for 1 IF unit: Overturned

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 Interferential Current Stimulation (ICS) Page(s): 118-120.

Decision rationale: The patient presents with pain in neck, back and bilateral extremities rated at 8/10, as per progress report dated 09/03/14. The request is for Prospective request for 1 IF unit. The patient is status post bilateral laminotomies, foraminotomies, medial facetectomy and diskectomy at L4-5 with decompression of neural elements, as per operative report dated 11/18/14 (after the UR date). For Interferential Current Stimulation (ICS), MTUS guidelines, pages 118 - 120, state that "Not recommended as an isolated intervention. There is no quality evidence of effectiveness except in conjunction with recommended treatments, including return to work, exercise and medications, and limited evidence of improvement on those recommended treatments alone." These devices are recommended in cases where (1) Pain is ineffectively controlled due to diminished effectiveness of medications; or (2) Pain is ineffectively controlled with medications due to side effects; or (3) History of substance abuse; or (4) Significant pain from postoperative conditions limits the ability to perform exercise programs/physical therapy treatment; or (5) Unresponsive to conservative measures (e.g., repositioning, heat/ice, etc.). Although there is a request for an IF unit, the treater does not explain the need. As per progress report dated 08/27/14, the patient takes Norco and Cyclobenzaprine to manage the pain. There is no evidence that medications and conservative measures are ineffective or that the patient has a history of substance abuse. The treater does not document side effects due to medication as well. The patient is status post bilateral laminotomies, foraminotomies, medial facetectomy and diskectomy at L4-5 with decompression of neural elements, as per operative report dated 11/18/14 (after the UR date). MTUS recommends IF units to patients with " Significant pain from postoperative conditions limits the ability to perform exercise programs/physical therapy treatment." The prospective request may be for post-surgical use although the treater does not document the need clearly. The request is medically necessary.

Prospective request for 1 hot and cold unit: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Neck & Upper Back (Acute & Chronic), Continuous-flow cryotherapy

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back - Lumbar & Thoracic (Acute & Chronic) chapter, Cold/heat packs

Decision rationale: The patient presents with pain in neck, back and bilateral extremities rated at 8/10, as per progress report dated 09/03/14. The request is for prospective request for 1 hot and cold unit. The patient is status post bilateral laminotomies, foraminotomies, medial facetectomy and discectomy at L4-5 with decompression of neural elements, as per operative report dated 11/18/14 (after the UR date). ODG Guidelines, chapter 'Low Back - Lumbar & Thoracic (Acute & Chronic)' and topic 'Cold/heat packs', states that hot/cold treatments are "Recommended as an option for acute pain. At-home local applications of cold packs in first few days of acute complaint; thereafter, applications of heat packs or cold packs." Although the treater requests for hot and cold unit, there is no explanation for it. ODG guidelines support the use of heat/cold treatments in patients with back pain. However, the progress reports do not specify the type of unit and extent of use. The reports lack relevant information required to make a determination. The request is not medically necessary.

1 prescription of Mentherm gel 240gm: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics; Salicylate topicals.

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

Decision rationale: The patient presents with pain in neck, back and bilateral extremities rated at 8/10, as per progress report dated 09/03/14. The request is for 1 prescription of Mentherm gel 240 gm. The patient is status post bilateral laminotomies, foraminotomies, medial facetectomy and discectomy at L4-5 with decompression of neural elements, as per operative report dated 11/18/14 (after the UR date). Mentherm gel contains Methyl salicylate and Menthol. Regarding topical NSAIDs MTUS page 111 states, "Indications: Osteoarthritis and tendinitis, in particular, that of the knee and elbow or other joints that are amenable to topical treatment." There is little evidence to utilize topical NSAIDs for treatment of osteoarthritis of the spine, hip or shoulder. Neuropathic pain: Not recommended as there is no evidence to support use." In this case, the prescription for mentherm gel only appears with the request in progress report dated 08/27/14. The patient suffers from chronic pain in neck, back and the extremities. However, there is no diagnosis of osteoarthritis and tendinitis of knee, elbow or other joints. The treater does not discuss the specific need for this cream. Topical NSAIDs are not indicated for spinal or other major joint conditions such as shoulder and hips. Additionally, MTUS page 60 requires recording of pain and function when medications are used for chronic pain. This request is not medically necessary.

