

Case Number:	CM14-0207337		
Date Assigned:	12/19/2014	Date of Injury:	06/08/2014
Decision Date:	02/27/2015	UR Denial Date:	12/03/2014
Priority:	Standard	Application Received:	12/10/2014

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
 State(s) of Licensure: New York, Tennessee
 Certification(s)/Specialty: Emergency Medicine

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 47-year-old male who was injured on June 8, 2014. The patient continued to experience pain in his neck, left shoulder, and right shoulder. Physical examination was notable for decreased range of motion of the cervical spine, and normal motor strength of the upper extremities. Diagnoses included cervical C6-7 degenerative disc disease with radiculopathy, thoracic and lower lumbar chronic sprain/strain, left shoulder posttraumatic arthritis, and left knee recurrent synovitis. Treatment included massage therapy, chiropractic therapy, acupuncture, and physical therapy. Requests for authorization for TENS unit 3 month trial, urine drug screen, topical analgesic containing ketoprofen/gabapentin/ tramadol and Xforce solar care were submitted for consideration.

IMR ISSUES, DECISIONS AND RATIONALES

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

3 month trial: TENS unit: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS, chronic pain (transcutaneous electrical nerve stimulation).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Pain Interventions and Guidelines Page(s): 114-115.

Decision rationale: TENS units are 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, including reductions in medication use, for neuropathic pain, phantom limb pain, spasticity, and multiple sclerosis. Several published evidence-based assessments of transcutaneous electrical nerve stimulation (TENS) have found that evidence is lacking concerning effectiveness. Functional restoration programs (FRPs) are designed to use a medically directed, interdisciplinary pain management approach geared specifically to patients with chronic disabling occupational musculoskeletal disorders. These programs emphasize the importance of function over the elimination of pain. FRPs incorporate components of exercise progression with disability management and psychosocial intervention. The patient was not participating in a functional restoration program. In addition the recommended trial period is one month. The duration of the requested 3 month trial surpasses the recommended one month trial. The TENS unit is therefore not recommended.

1 urine toxicology test: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, steps to avoid misuse/addiction.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Pain Interventions and Guidelines Page(s): 78.

Decision rationale: Chronic Pain Medical Treatment Guidelines state that urinary drug testing should be used if there are issues of abuse, addiction, or pain control in patients being treated with opioids. ODG criteria for Urinary Drug testing are recommended for patients with chronic opioid use. Patients at low risk for addiction/aberrant behavior should be tested within 6 months of initiation of therapy and yearly thereafter. Those patients with moderate risk for addiction/aberrant behavior should undergo testing 2-3 times/year. Patients with high risk of addiction/aberrant behavior should be tested as often as once per month. In this case the patient is not taking any medications. Urine drug testing is therefore not indicated. The request is not medically necessary.

1 prescription of topical creams (Ketoprofen/Gabapentin/Tramadol): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Medications.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Pain Interventions and Guidelines Page(s): 74-96, 111-112.

Decision rationale: Topical analgesics are recommended for neuropathic pain when anticonvulsants and antidepressants have failed. Compounded topical analgesics are commonly prescribed and there is little to no research to support the use of these compounds. Furthermore,

the guidelines state that any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Ketoprofen is not currently FDA approved for a topical application. It has an extremely high incidence of photocontact dermatitis. Absorption of the drug depends on the base it is delivered in. Topical treatment can result in blood concentrations and systemic effect comparable to those from oral forms, and caution should be used for patients at risk, including those with renal failure. It is not recommended. Gabapentin is not recommended. There is no peer-reviewed literature to support use. Tramadol is a synthetic opioid affecting the central nervous system. It has several side effects, which include increasing the risk of seizure in patients taking TCA and other opioids. It is not recommended as a topical preparation. The guidelines state that any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. This medication contains drugs that are not recommended. Therefore the medication cannot be recommended. The request should not be authorized.

1 XForce Solar Care: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back - Lumbar & Thoracic (Acute & Chronic)

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, Infrared therapy.

Decision rationale: X- force Solar care is a device for infrared therapy. Infrared therapy is not recommended over other heat therapies. Where deep heating is desirable, providers may consider a limited trial of IR therapy for treatment of acute low back pain, but only if used as an adjunct to a program of evidence-based conservative care (exercise). ODG has no recommendation for infrared therapy for neck pain. In this case the patient is being treated for chronic neck pain. Heat applications are recommended for the treatment of neck pain. 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 affects, local applications of cold packs may be applied during first few days of symptoms followed by applications of heat packs to suit patient. Heat packs would provide sufficient heat therapy. There is no indication for the use of the X-Force solar device. The request should not be authorized.