

Case Number:	CM15-0106819		
Date Assigned:	06/11/2015	Date of Injury:	09/27/2014
Decision Date:	07/13/2015	UR Denial Date:	06/01/2015
Priority:	Standard	Application Received:	06/02/2015

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: California
Certification(s)/Specialty: Internal 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 injured worker is a 45 year old female, who sustained an industrial injury on 9/27/2014. She reported injury while assisting a patient. The injured worker was diagnosed as having lumbosacral sprain/strain and lumbar herniated nucleus pulposus. Documentation states the injured worker had a lumbar magnetic resonance imaging that showed a disc herniation at lumbar 4-5. Treatment to date has included physical therapy and medication management. In a progress note dated 5/8/2015, the injured worker complains of low back pain, rated 8/10. Physical examination showed thoracolumbar tenderness and decreased range of motion. The treating physician is requesting topical Cyclo 10%, Ultram 10% twice a day refill 1 and a solar care FIR heating system for the lower back.

IMR ISSUES, DECISIONS AND RATIONALES

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

Topical Cyclo 10%, Ultram 10% twice a day refill 1: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment Page(s): 49, Chronic Pain Treatment Guidelines Topical analgesics Page(s): 111.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page 111-113.

Decision rationale: Medical Treatment Utilization Schedule (MTUS) Chronic Pain Medical Treatment Guidelines address topical analgesics. Topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. There is little to no research to support the use of many of these agents. There is no evidence for use of a muscle relaxant as a topical product. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. The patient injured the lower back in September 2014. The orthopedic progress report dated December 8, 2014 documented the diagnosis of lumbar spine sprain and strain, sciatica, and L5 radiculopathy. The primary treating physician's progress report dated May 8, 2015 documented low back pain and right lower extremity complaints. MTUS Chronic Pain Medical Treatment Guidelines do not support the use of topical products containing the muscle relaxant Cyclobenzaprine. Per MTUS, any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. MTUS does not support the use of a topical product containing the muscle relaxant Cyclobenzaprine. Therefore, the request for topical product containing Cyclobenzaprine and Ultram is not supported by MTUS. Therefore, the request for topical Cyclobenzaprine 10 Percent and Ultram 10 Percent is not medically necessary.

DME; Solar care FIR heating system, lower back: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Low back & Lumbar & thoracic.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back (Acute & Chronic) Infrared therapy (IR). Work Loss Data Institute Low back <http://www.guideline.gov/content.aspx?id=47586>.

Decision rationale: Medical Treatment Utilization Schedule (MTUS) addresses passive modalities. American College of Occupational and Environmental Medicine (ACOEM) Chapter 12 Low Back Complaints indicates that physical modalities such as massage, diathermy, cutaneous laser treatment, ultrasound, transcutaneous electrical neurostimulation (TENS) units, percutaneous electrical nerve stimulation (PENS) units, and biofeedback have no proven efficacy in treating acute low back symptoms. Insufficient scientific testing exists to determine the effectiveness of these therapies. ODG guidelines indicate that infrared heat is not recommended over other heat therapies. Work Loss Data Institute guidelines indicate that infrared therapy is not recommended for low back disorders. The patient injured the lower back in September 2014. The orthopedic progress report dated December 8, 2014 documented the diagnosis of lumbar spine sprain and strain, sciatica, and L5 radiculopathy. The primary treating physician's progress report dated May 8, 2015 documented low back pain and right lower extremity complaints. ODG guidelines indicate that infrared heat is not recommended over other heat therapies. Work Loss Data Institute guidelines indicate that infrared therapy is not recommended for low back

disorders. The request for an infrared device is not supported by clinical practice guidelines. Therefore, the request for a SolarCare FIR infrared heating system is not medically necessary.