

<b>Case Number:</b>	CM15-0147189		
<b>Date Assigned:</b>	08/10/2015	<b>Date of Injury:</b>	10/12/2001
<b>Decision Date:</b>	09/28/2015	<b>UR Denial Date:</b>	07/14/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/29/2015

### 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: Physical Medicine & Rehabilitation

### 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 62 year old female who sustained an industrial injury on 10-12-01. The injured worker was diagnosed as having lumbar disc injury with radiculopathy, segmental dysfunction, lumbar spine, chronic lumbosacral sprain-strain and post-traumatic myofascial pain. Currently, the injured worker reported back discomfort. Previous treatments included oral pain medication, epidural steroid injection, physical therapy, chiropractic treatments, oral muscle relaxant, activity modification, psychological testing, anti-inflammatory medications and nonsteroidal anti-inflammatory drugs. Previous diagnostic studies included a magnetic resonance imaging, radiographic studies and electrodiagnostic studies. Work status was noted as permanent and stationary. The injured workers pain level was not noted. Physical examination was not noted. The plan of care was for a retrospective of LidoPro cream 121 grams (date of service 07-07-15) and a retrospective transcutaneous electrical nerve stimulation (TENS) unit patches times 2 pairs (date of service 07-07-15).

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Retrospective Lidopro cream 121gm (DOS 07-07-15): Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints, Chronic Pain Treatment Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111.

**Decision rationale:** The patient was injured on 10/21/01 and presents with lumbar spine pain. The retrospective request is for Lidopro Cream 121 Gm (DOS 07-07-15). There is no RFA provided and the patient is permanent and stationary. LidoPro lotion contains capsaicin, lidocaine, menthol, and methyl salicylate. Regarding topical analgesics, MTUS Guidelines page 111 has the following regarding topical cream, "topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety." MTUS further states, "Any compounded product that contains at least 1 (or 1 drug class) that is not recommended is not recommended." The patient is diagnosed with lumbar disc injury with radiculopathy, segmental dysfunction, lumbar spine, chronic lumbosacral sprain-strain and post-traumatic myofascial pain. MTUS Guidelines do not allow any other formulation of lidocaine other than in patch form. MTUS Guidelines do not recommend a compounded product if one of the compounds are not indicated for use. Since lidocaine is not indicated for this patient in a non- patch form, the entire compound is not recommended. Therefore, the requested LidoPro Cream is not medically necessary.

**Retrospective transcutaneous electrical nerve stimulation (TENS) unit patches times 2 pairs (DOS 07-07-15):** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints, Chronic Pain Treatment Guidelines Page(s): 116.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines TENS Chronic Pain (Transcutaneous Electrical Nerve Stimulation) Page(s): 116.

**Decision rationale:** The patient was injured on 10/21/01 and presents with lumbar spine pain. The retrospective request is for Transcutaneous Electrical Nerve Stimulation (Tens) Unit Patches Times 2 Pairs (DOS 07-07-15). There is no RFA provided and the patient is permanent and stationary. MTUS Guidelines, TENS Chronic Pain Transcutaneous Electrical Nerve Stimulation, page 116 states that TENS unit have not proven efficacy in treating chronic pain and is not recommend as a primary treatment modality, but a 1-month home-based trial may be considered for a specific diagnosis of neuropathy, CRPS, spasticity, a phantom limb pain, and multiple sclerosis. When a TENS unit is indicated, a 30-day home trial is recommended, and with the documentation of functional improvement, additional usage maybe indicated. The patient is diagnosed with lumbar disc injury with radiculopathy, segmental dysfunction, lumbar spine, chronic lumbosacral sprain-strain and post-traumatic myofascial pain. Treatment to date includes oral pain medication, epidural steroid injection, physical therapy, chiropractic treatments, oral muscle relaxant, activity modification, psychological testing, anti-inflammatory medications, and non-steroidal anti-inflammatory drugs. In this case, there is no mention of the patient previously using the TENS unit for a 1-month trial as required by MTUS guidelines. There are no discussions regarding any outcomes for pain relief and function. A trial of TENS may be reasonable. However, it is unclear if the treater is requesting for a one-month trial or a purchase. Therefore, the request is not medically necessary.