

Case Number:	CM15-0191547		
Date Assigned:	10/06/2015	Date of Injury:	03/19/2001
Decision Date:	11/18/2015	UR Denial Date:	09/04/2015
Priority:	Standard	Application Received:	09/29/2015

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, Hawaii

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 48 year old male, who sustained an industrial injury on March 19, 2001, incurring low back injuries. He was diagnosed with displacement of lumbar intervertebral disc, lumbago, and thoracic neuritis and radiculitis. He underwent a lumbar laminectomy and lumbar fusion. Treatment included anti-inflammatory drugs, pain medications, topical analgesic cream, muscle relaxants, physical therapy, injections and a spinal cord stimulator trial, which failed for relief of his pain. Currently, the injured worker complains of constant low back pain with radiation to the bilateral lower extremities rating his pain 8 out of 10 on a pain scale from 0 to 10, describing the pain as hot burning, stabbing, numbing and tingling. Activities such as bending, standing and sitting aggravated his pain while medications and rest helped the pain. The treatment plan that was requested for authorization on September 29, 2015, included a prescription for Norco 10-325 #150, a prescription for Icy Hot topical cream 100 gm and a prescription for Thermacare wraps #60. On September 4, 2015, a prescription for Norco #130 was modified to Norco #113, a prescription for Icy Hot cream was non-certified, and a prescription for Thermacare wraps was non-certified by utilization review.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 Prescription of Norco 10/325 #150: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids, criteria for use.

Decision rationale: The patient presents with diagnoses that include displacement of lumbar intervertebral disc, lumbago, post laminectomy syndrome lumbar region and thoracic/lumbosacral neuritis and radiculitis as well as failed spinal cord stimulator trial. The patient currently complains of constant low back pain with radiation to the bilateral lower extremities. The current request is for 1 Prescription of Norco 10/325 #150. The treating physician states in the treating report dated 9/15/15 (11C), "Medication: Norco 10 mg-325mg tablet 1 Tablet Five Times Daily for 30 Days, Dispense 150 Tablet." For chronic opiate use, MTUS Guidelines pages 88 and 89 states, "Pain should be assessed at each visit, and functioning should be measured at 6-month intervals using a numerical scale or validated instrument." MTUS page 78 also requires documentation of the 4As (analgesia, ADLs, adverse side effects, and aberrant behavior), as well as "pain assessment" or outcome measures that include current pain, average pain, least pain, intensity of pain after taking the opioid, time it takes for medication to work and duration of pain relief. In this case, the treating physician clearly documents the patient's analgesia and ADLs, as well as his lack of adverse side effects and aberrant behaviors while on his current medication regimen. The current request is medically necessary.

1 Prescription of Icy hot topical cream 100gms: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Topical Analgesics.

Decision rationale: The patient presents with diagnoses that include displacement of lumbar intervertebral disc, lumbago, post laminectomy syndrome lumbar region and thoracic/lumbosacral neuritis and radiculitis as well as failed spinal cord stimulator trial. The patient currently complains of constant low back pain with radiation to the bilateral lower extremities. The current request is for 1 Prescription of Icy hot topical cream 100gms. The treating physician states in the treating report dated 9/15/15 (11C), "Medication: Icy Hot topical cream 1 As Needed for 30 Days, Dispense 100 Gram." Icy Hot products contain menthol, a combination of menthol and camphor, and a combination of menthol and methyl salicylate. These ingredients create cooling and warming sensations that divert attention from the actual pain and help block the pain signals being sent to the brain. MTUS Guidelines do not address Icy Hot by name but do discuss Salicylate topicals. MTUS states, "Recommended. Topical salicylate (e.g., Ben-Gay, methyl salicylate) is significantly better than placebo in chronic pain." In this case, the clinical history clearly documents that the patient suffers from chronic pain and

obtains relief with the use of the requested treatment. The current request is medically necessary.

1 Prescription of TheraCare wraps #60: Overturned

Claims Administrator guideline: Decision based on MTUS Low Back Complaints 2004.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Low Back, Heat Therapy.

Decision rationale: The patient presents with diagnoses that include displacement of lumbar intervertebral disc, lumbago, post laminectomy syndrome lumbar region and thoracic/lumbosacral neuritis and radiculitis as well as failed spinal cord stimulator trial. The patient currently complains of constant low back pain with radiation to the bilateral lower extremities. The current request is for 1 prescription of TheraCare wraps #60. The treating physician states in the treating report dated 9/15/15 (11C), "Medication: Thera wrap pads 1-2 Once A Day for 30 Days, Dispense 60 Patch, Refills 5." MTUS is silent regarding the proposed treatment. ACOEM Guidelines pages 156, 157 recommend heat therapy for low back pain. The ODG Guidelines under the low back chapter for heat therapy topics states, "Recommended as an option." The ODG further states "one study compared the effectiveness of [REDACTED] back plaster, the [REDACTED] Warme-Pflaster, and the [REDACTED] TheraCare heat wrap, and concluded that TheraCare heat wrap is more effective than the other two." The treating physician states that the patient is able to manage his pain and perform ADL while on the current medications. Heat therapy is recommended as an option as indicated by ODG Guidelines and it is noted that current medications including Thera heat patches provides a reduction in pain. The current request is medically necessary.