

Case Number:	CM15-0210549		
Date Assigned:	10/29/2015	Date of Injury:	06/05/2006
Decision Date:	12/22/2015	UR Denial Date:	10/09/2015
Priority:	Standard	Application Received:	10/26/2015

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: Pennsylvania, Ohio, 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 40 year old male who sustained an industrial injury on 06-05-2006. Medical records indicated the worker was treated for lumbar sprain and strain. In the provider notes of 09-18-2015, the injured worker complains of persistent pain in the lower back that is worsening and radiating to the left hip and left buttocks. This pain in the back and left hip are increasing. Treatment has included three lumbar epidural steroid injections, which gave temporary relief. On exam, the worker has decreased range of motion with tenderness over the paraspinals equally. Kemp's sign was positive bilaterally with slightly decreased range of motion. Straight leg raise was positive on the left at 60 degrees for the posterior thigh. The left L4, L5, and S1 have decreased strength and sensation. Deep tendon reflexes were 2+ bilaterally at the patellar and Achilles tendons. The worker has multiple injuries and complaints. The treatment plan includes physical therapy and Kera-Tek gel in order to help the worker wean from Motrin and Omeprazole due to his gastrointestinal issues. Work status is no use of the injured extremity and lifting limited to 5 lbs. The treatment plan included requesting a MRI of the lumbar spine without contrast, physical therapy for the lumbar spine, a large heating pad, a 3- month trial of transcutaneous electrical nerve stimulation (TENS) unit, and topically applied medications. A request for authorization was submitted 09-30-2015 for: 1. TENS Unit 3 Month Rental. 2. Kera-Tek (Methyl Salicylate/Menthol) Gel 4 OZ. 3. Large Heating Pad. A utilization review decision 10/09/2015 non-certified: TENS Unit 3 Month Rental; Kera-Tek (Methyl Salicylate/Menthol) Gel 4 OZ; Large Heating Pad.

IMR ISSUES, DECISIONS AND RATIONALES

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

TENS Unit 3 Month Rental: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Transcutaneous electrotherapy.

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

Decision rationale: MTUS recommends a 1-month TENS trial as part of an overall functional restoration program for a neuropathic pain diagnosis. The records at this time do not clearly document a neuropathic pain diagnosis for which TENS would be indicated, nor do the records document functional restorative goals for TENS in this chronic setting. Moreover, the request for a 3-month trial exceeds treatment guidelines without a rationale for an exception. Therefore a TENS rental and associated supplies are not medically necessary.

Kera-Tek (Methyl Salicylate/Menthol) Gel 4 OZ: Upheld

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

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

Decision rationale: MTUS recommends the use of compounded or topical analgesics only if there is documentation of the specific proposed analgesic effect and how it will be useful for the specific therapeutic goal required. The records in this case do not provide such a rationale for this topical medication or its ingredients. This request is not medically necessary.

Large Heating Pad: 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).

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

Decision rationale: MTUS encourages physical therapy with an emphasis on active forms of treatment and patient education. This guideline recommends transition from supervised therapy to active independent home rehabilitation. MTUS recommends use of passive thermal modalities such as a heating pad in the immediate acute phase of an injury; however, neither the guidelines nor the records provide a rationale instead for such modalities in such a chronic phase as the current request. This request is not medically necessary.