

<b>Case Number:</b>	CM15-0033073		
<b>Date Assigned:</b>	02/26/2015	<b>Date of Injury:</b>	06/10/2004
<b>Decision Date:</b>	04/14/2015	<b>UR Denial Date:</b>	01/30/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/23/2015

### 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: New York  
 Certification(s)/Specialty: Anesthesiology

### 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 61-year-old female who sustained an industrial injury on 6/10/04. The injured worker reported symptoms in the back and bilateral hips. The diagnoses included left shoulder biceps tendinitis versus biceps tendon rupture, bilateral impingement syndrome, bilateral medial epicondylitis, possible left medial capsulitis, left shoulder arthroscopy on 5/11/05, bilateral knee chondromalacia, left wrist pain and lumbar spine contusion. Treatments to date include physical therapy and status post left shoulder arthroscopy on 5/11/05. In a progress note dated 1/16/15 the treating provider reports the injured worker was with "aching pain the lower back is constant at 6/10. Her aching pain in the bilateral hips is constantly at 8/10." On 1/30/15 Utilization Review non-certified the request for interferential unit, Acupuncture; eight (8) visits (2 times 4), magnetic resonance imaging, bilateral hips and Ketoprofen/gabapentin/diclofenac/lidocaine 15/8/5/5%; apply 1-2 grams to affected area, 180 grams. The MTUS, ACOEM Guidelines, (or ODG) was cited.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Interferential unit:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrotherapy, Interferential Current Stimulation (ICS).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation (ICS) Page(s): 118.

**Decision rationale:** According to MTUS, Interferential Current Stimulation (ICS) is not recommended as an isolated intervention. There is no quality evidence of effectiveness except in conjunction with recommended treatments, including return to work, exercise and medications, and limited evidence of improvement on those recommended treatments alone. There are no standardized protocols for the use of interferential therapy; and the therapy may vary according to the frequency of stimulation, the pulse duration, treatment time, and electrode-placement technique. The guidelines state that ICS is recommended when pain is ineffectively controlled due to a history of substance abuse or there is significant pain from post-operative conditions that limits the ability to perform exercise programs/physical therapy treatment. In this case, there is no specific indication for the use of ICS. Medical necessity for the requested intervention has not been established. The requested ICS is not medically necessary.

**Acupuncture; eight (8) visits (2 times 4): Upheld**

**Claims Administrator guideline:** Decision based on MTUS Acupuncture Treatment Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Acupuncture Treatment Guidelines, Chronic Pain Treatment Guidelines CA MTUS Page(s): 8-9.

**Decision rationale:** The California MTUS Acupuncture guidelines apply to all acupuncture requests, for all body parts and for all acute or chronic, painful conditions. According to the Acupuncture Medical Treatment Guidelines, acupuncture is used as an option when pain medication is reduced or not tolerated. It may be used as an adjunct to physical rehabilitation and/or surgical intervention to hasten recovery. The treatment guidelines support acupuncture treatment to begin as an initial treatment of 3-6 sessions, with a frequency of 1 to 3 times per week, with a duration of 1 to 2 months. If functional improvement is documented, as defined by the guidelines further treatment will be considered. In this case, the requested acupuncture sessions (8 sessions with 2 sessions/week over 4 weeks) exceed the recommended 3-6 sessions over 1 to 2 months. Medical necessity of the requested acupuncture has not been established. The requested acupuncture sessions are not medically necessary.

**MRI, bilateral hips: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG0, Hip & Pelvis Chapter, MRI (magnetic resonance Imaging) section.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Hip and Pelvis Chapter.

**Decision rationale:** The ODG states that MRI seems to be the modality of choice in evaluation of select patients in whom plain radiographs are negative, and the suspicion is high for occult fracture. This imaging is highly sensitive and specific for hip fractures. Even if a fracture is not revealed, other pathology responsible for the patient's symptoms may be detected, which will direct treatment plans. MRI shows superior sensitivity in detecting hip and pelvic fractures over plain film radiography. In this case, there is no documentation of the medical rationale for the requested MRI study. Medical necessity for the requested MRI, bilateral hips, is not established. The requested MRI is not medically necessary.

**Ketoprofen/gabapentin/diclofenac/lidocaine 15/8/5/5%; apply 1-2 grams to affected area, 180gm:** Upheld

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

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

**Decision rationale:** According to the California MTUS Guidelines (2009), topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. These agents are applied topically to painful areas with advantages that include lack of systemic side effects, absence of drug interactions, and no need to titrate. Many agents are compounded as monotherapy or in combination for pain control including, for example, NSAIDs, opioids, capsaicin, muscle relaxants, local anesthetics or antidepressants. Guidelines indicate that any compounded product that contains at least 1 non-recommended drug (or drug class) is not recommended for use. In this case, the topical analgesic compound is Ketoprofen 15%/gabapentin 8%/diclofenac 5%/lidocaine. Gabapentin is not recommended as a topical agent per CA MTUS Guidelines, and there is no peer-reviewed literature to support its use. Ketoprofen is not currently FDA approved for a topical application, and has an extremely high incidence of photocontact dermatitis. In addition, there is no documentation of intolerance to other previous oral medications. Medical necessity for the requested topical analgesic compound has not been established. The requested topical analgesic is not medically necessary.