

Case Number:	CM15-0078055		
Date Assigned:	04/29/2015	Date of Injury:	09/29/2012
Decision Date:	08/21/2015	UR Denial Date:	04/06/2015
Priority:	Standard	Application Received:	04/23/2015

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: California

Certification(s)/Specialty: Emergency 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 33-year-old male, who sustained an industrial injury on September 29, 2012. He has reported back pain, knee pain, ankle pain and foot pain. Diagnoses have included cavovarus deformity and metatarsus adductus bilaterally with injury to the peroneal tendon, some element of chronic regional pain syndrome, discogenic lumbar condition with facet inflammation, internal derangement of the right knee, and right ankle sprain. Treatment to date has included medications, use of a cane, transcutaneous electrical nerve stimulator unit, bracing, and surgery. A progress note dated March 10, 2015 indicates a chief complaint of left ankle pain, left foot pain, lower back pain, and right knee pain. The treating physician documented a plan of care that included medications, urine drug screen, psychiatric consultation, interferential unit with conductive garment, and hot/cold wrap.

IMR ISSUES, DECISIONS AND RATIONALES

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

DME- IF Unit (indefinite use) Qty: 1.00: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation (ICS) Page(s): 118-120.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 118-119. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back.

Decision rationale: The request is for the use of Interferential therapy to aid in pain relief. It has been postulated that Interferential stimulation allows for deeper penetration of tissue, whereas TENS is predominantly a superficial stimulus. The MTUS guidelines states that this is not recommended as an isolated event with lacking quality evidence of effectiveness. The randomized trials that have evaluated the effectiveness of this treatment have included studies for back pain, jaw pain, soft tissue shoulder pain, cervical neck pain and post-operative knee pain. There is insufficient literature to support Interferential current stimulation for the treatment of these conditions. The ODG guidelines states that its use for low back pain is generally not recommended. In this case the documentation does not support the use of this treatment modality. As such, the request is not necessary.

DME- Conductive Garment Qty: 1.00: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation (ICS) Page(s): 118-120.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 118-119. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back.

Decision rationale: The request is for a conductive garment, which is used with an electrical nerve stimulation unit. The unit in use is an interferential stimulator. The request for the Interferential stimulation unit was not certified for use. As such, the need for use of this component of the device would not be necessary. As such, the request is necessary.

Tramadol ER 150mg Qty: 30.00: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Tramadol (Ultram) Page(s): 93-94, and 113.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 80-83.

Decision rationale: Tramadol is a pain medication in the category of a centrally acting analgesic. They exhibit opioid activity and a mechanism of action that inhibits the reuptake of serotonin and norepinephrine. Centrally acting drugs are reported to be effective in managing neuropathic type pain although it is not recommended as first line therapy. The side effect profile is similar to opioids. For chronic back pain, it appears to be efficacious for short term pain relief, but long term (>16 weeks) results are limited. It also did not appear to improve function. The use of tramadol for osteoarthritis is indicated for short term use only (<3 months) with poor long-term benefit. In this case, the patient does not meet the qualifying criteria or indications. As such, the request is not medically necessary.

Cyclobenzaprine 7.5mg Qty: 60.00: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain) Page(s): 64-66.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): (s) 41-42.

Decision rationale: The request is for the use of Cyclobenzaprine. This medication is classified as a muscle relaxant and central nervous system depressant with side effects including drowsiness and dizziness. The MTUS guidelines states that it is indicated for short term use for low back pain. The effect seems to be greatest the first 4 days of use, which suggests that treatment should be brief. In this case, due to the duration of treatment, further use would not be indicated. As such, the request is not medically necessary.

LidoPro Cream Qty: 1.00: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical analgesics Page(s): 111-113.

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

Decision rationale: The request is for the use of a compounded medication for topical use to aid in pain relief. These products contain multiple ingredients, which each have specific properties and mechanisms of action. The MTUS guidelines state the following: "Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended". In this case, the use of lidocaine cream is stated to be not indicated for use for the patient's condition. As such, the request is not medically necessary.

DME - How/Cold wrap Qty: 1.00: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Ankle & Foot: Heat therapy (ice/heat).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment Page(s): 48.

Decision rationale: The request is for the use of hot or cold treatment to be applied topically to aid in pain relief. The ACOEM guidelines under Physical Methods states that during the acute to subacute phase of injury over the first 2 weeks, application of hot or cold can be effective in ameliorating symptoms. This would aid in facilitation of mobility and exercise. Due to the longstanding duration after injury, continued use would not be indicated in this case. As such, the request is not medically necessary.

