

<b>Case Number:</b>	CM14-0117625		
<b>Date Assigned:</b>	09/16/2014	<b>Date of Injury:</b>	10/31/2012
<b>Decision Date:</b>	10/28/2014	<b>UR Denial Date:</b>	07/07/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/28/2014

### 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. The expert reviewer is Board Certified in Anesthesiology, has a subspecialty in Pain Medicine and is licensed to practice in Texas. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

This injured worker is a 26 year old male with a date of injury of 10/31/12. The mechanism of injury is described as lifting a product with pain being produced. The submitted records indicate that the initial diagnosis was a lumbar strain and sprain, sciatica, and lumbago. The injured worker has been treated conservatively with medications and restricted work activities. Previous determination indicated that the requested treatment in the form of chiropractic treatment, Diclofenac Sodium, LidoPro ointment, Tramadol, and transcutaneous electrical nerve stimulation electrodes 2 sets, was not supported. The submitted records indicate the injured worker was last seen on 07/24/14, and no additional notes were provided.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Chiropractic treatment X6 visits:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines no chapter noted.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy Page(s): 58.

**Decision rationale:** The submitted records do not include an updated clinical note to warrant this treatment at this time. While the records indicate that there has been a lumbar strain and sprain,

the records do not indicate exactly how many therapy sessions this injured worker has already undergone. The date of injury 10/31/12 indicates this is a chronic issue. While guidelines do support some conservative care for chronic issues, for maintenance of low back issues, chiropractic treatment is not supported. If there is a flare, chiropractic treatment can be supported for one to two treatments but the records do not indicate a flare of this injured worker's pain has occurred. Therefore, this request is not medically necessary.

**Diclofenac Sodium ER 100mg #30:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines nonsteroidal antiinflammatory drugs (NSAIDs) Page(s): 67-71.

**Decision rationale:** This request is for an NSAID. MTUS Chronic Pain Guidelines indicate this medication may be used but for the shortest period of time at the lowest dosage for those who have moderate to severe pain. For lesser pain, acetaminophen is recommended by MTUS chronic pain guidelines. The records do not include current updated note to indicate that there is significant pain and/or inflammation for the injured worker. The records do not indicate that there has been updated laboratory analysis to indicate that this type of medication is not causing adverse events for this injured worker. As such, this request is not medically necessary.

**Lidopro ointment 121gm:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines anti epileptic.

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

**Decision rationale:** This is for a LidoPro ointment, also known as a topical ointment. MTUS Chronic Pain Guidelines indicate that topical ointments or creams are largely experimental in nature and have few randomized controlled trials documenting their efficacy and/or safety. This cream has capsaicin as an ingredient. MTUS chronic pain guidelines state that capsaicin is only recommended for those who have failed other therapies or cannot tolerate other therapies. There is lack of an updated clinical exam to warrant this medication at this time. Therefore, this request is not medically necessary.

**Tramadol 50mg #90:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines chapter not cited.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids-Ongoing management page Page(s): 113, 78.

**Decision rationale:** This request is for Tramadol. MTUS Chronic Pain Guidelines indicate that there should be adherence to the 4 A's for this type of medication. The 4 A's included analgesia and activities of daily living as well as adverse side effects and aberrant drug taking behavior. The records do not indicate significant functional improvement with this medication and do not indicate lack of aberrant drug taking behaviors. This medication is also not a first line treatment. The records do not indicate failure of lesser measures or adherence to the 4 A's. As such, this medication is not supported at this time and the recommendation is not medically necessary.

**Transcutaneous electrical nerve stimulation electrodes 2 sets:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines no chapter noted.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines TENS Page(s): 114.

**Decision rationale:** My rationale for why the requested treatment is not medically necessary is that this is for electrodes for TENS unit. Guidelines indicate that TENS units may be considered reasonable but only for a trial of a 1 month period. During that one month trial, the efficacy of the treatment should be documented with documentation of decreased pain scores, and there should be documentation of the actual time of usage for the unit. As this has not been documented, continued use of a TENS unit is not supported and therefore there would be no need for TENS unit pads or electrodes. This request is not medically necessary.