

<b>Case Number:</b>	CM14-0135915		
<b>Date Assigned:</b>	09/03/2014	<b>Date of Injury:</b>	06/08/1999
<b>Decision Date:</b>	09/29/2014	<b>UR Denial Date:</b>	08/20/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/22/2014

### 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 Physical Medicine and Rehabilitation and is licensed to practice in Illinois. 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:

The injured worker is a 52-year-old male who reported an injury on 06/08/1999 due to an unknown mechanism. Diagnoses were failed back surgery syndrome, lumbar, lumbar postlaminectomy syndrome, lumbar radiculopathy, status post fusion, lumbar spine, right knee pain, diabetes mellitus, chronic pain, other, left foot infection not on claim, treatment under FMC. Past treatments were TENS unit, physical therapy, home exercise program. Diagnostic studies were a nerve conduction study, x-rays of the lumbar spine. The x-rays demonstrated the internal fixation cage was well positioned at the L4-5 without signs of slippage. Surgical history was postlaminectomy lumbar spine, status post fusion lumbar spine. Physical examination on 08/01/2014 revealed complaints of low back pain. The pain was reported to radiate down the bilateral lower extremities. It was reported that there was numbness frequently in the bilateral lower extremities. The injured worker reported having moderate difficulty during sleep. Pain was rated at 8/10 in intensity with medications, and 10/10 without medications, the pain was reported to be worsened since the last visit. Examination of the lumbar spine revealed tenderness was noted upon palpation of the spinals/vertebral area L4-S1 levels. Range of motion in the lumbar spine was moderately to severely limited. Pain was significantly increased with flexion and extension. Sensory examination revealed decreased sensitivity to touch along the L4-S1 dermatomes in both lower extremities. Straight leg raise in the seated position was positive bilaterally at 70 degrees. Medications were Bio-freeze, tramadol. The rationale was submitted but it was too long to add to the summary. The Request for Authorization was not submitted.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Unknown Three Month Supply Of Tens Unit Patches: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines TENS (Transcutaneous Electrical Nerve Stimulation).

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)- Knee, Durable Medical Equipment.

**Decision rationale:** The decision for Unknown Three Month Supply Of Tens Unit Patches is not medically necessary. This request falls under Durable Medical Equipment. The term Durable Medical Equipment is defined as equipment which can withstand repeated use, i.e., could normally be rented, and used by successive patients, is primarily and customarily used to survey medical purpose, and generally is not useful a person in absence of illness or injury, and is appropriate for use in a patient's home. It was reported that the injured worker has a TENS unit and uses it frequently during the day. Due to the fact that the request does not state the amount of patches that are needed, this request is not medically necessary.

**Unknown Prescription For Biofreeze 4% Gel: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines May 2009 Bio-freeze Cryotherapy Gel.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back Biofreeze Cryotherapy Gel.

**Decision rationale:** The decision for Unknown Prescription For Biofreeze 4% Gel is not medically necessary. The Official Disability Guidelines state for Bio-freeze cryotherapy gel is recommended as an optional form of cryotherapy for acute pain. Bio-freeze is a nonprescription topical cooling agent with the active ingredient menthol that takes the place of ice packs. Whereas ice packs only work for a limited period of time, Bio-freeze can last much longer before reapplication. This randomized controlled designed to determine the pain relieving effect of Bio-freeze on acute low back pain concluded that significant pain reduction was found after each week of treatment in the experimental group. The request does not indicate the number of Bio-freeze gels. It also does not indicate the frequency for the medication. Therefore, the request is not medically necessary.

**Tramadol 50mg, #120: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Tramadol- Opioid analgesics.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Tramadol, Ongoing Management Page(s): 78 82,93,94,113.

**Decision rationale:** The decision for Tramadol 50mg, #120 is not medically necessary. The California Medical Treatment Utilization Schedule states central analgesic drugs such as Tramadol (Ultram) are reported to be effective in managing neuropathic pain and it not recommended as a first line oral analgesic. The medical guidelines recommend that there should be documentation of the 4 A's for ongoing monitoring including analgesia, activities of daily living, adverse side effects, and aberrant drug taking behavior. The efficacy of this medication was not reported. Also, the request does not indicate a frequency for the medication. Therefore, the request is not medically necessary.