

<b>Case Number:</b>	CM14-0086311		
<b>Date Assigned:</b>	07/23/2014	<b>Date of Injury:</b>	02/04/2003
<b>Decision Date:</b>	09/25/2014	<b>UR Denial Date:</b>	05/20/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/09/2014

### 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 & Rehabilitation and is licensed to practice in California. 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 55-year-old male who reported an injury on 02/04/2003. The mechanism of injury involved a fall. Current diagnoses include lumbar spinal stenosis, degenerative disc disease with facet arthrosis and balance issues. The injured worker was evaluated on 04/21/2014. Previous conservative treatment includes medication management, physical therapy, and epidural steroid injections. The injured worker is also noted to have undergone a lumbar spine MRI on 03/20/2014. The injured worker presented with complaints of cervical spine, thoracic spine, and lumbar spine pain. Physical examination on that date revealed diffuse tenderness to palpation over the central and paralumbar location of L3 through S1, sciatic notch tenderness bilaterally, intact sensation, normal motor strength, and 2+ deep tendon reflexes. X-rays of the cervical spine obtained in the office on that date indicated moderately severe spondylosis with associated disc space narrowing at C4 through C6, grade 1 retrolisthesis at C5 on C6, and mild dynamic instability at C5-6. X-rays of the lumbar spine obtained in the office on that date indicated early degenerative changes at L3 through L5 with mild loss of disc height and negative instability. Treatment recommendations at that time included prescriptions for topical compounded creams, an X-force stimulator unit, a lumbar brace, a heating system, and an MRI of the cervical and thoracic spine. There was no request for authorization form submitted on the requesting date.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Kronos lumbar pneumatic brace; purchase: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300.

**Decision rationale:** The California MTUS/ACOEM Practice Guidelines state lumbar supports have not been shown to have any lasting benefit beyond the acute phase of symptom relief. There was no documentation of spinal instability upon physical examination. The medical necessity for the requested durable medical equipment has not been established. As such, the request is not medically appropriate.

**Solar - Care Heating system, purchase:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 298-300.

**Decision rationale:** The California MTUS/ACOEM Practice Guidelines state at-home local applications of heat or cold are as effective as those performed by a therapist. There is no mention of a contraindication to local applications of heat as opposed to a heating unit. The medical necessity has not been established. As such, the request is not medically appropriate.

**X-Force stimulator Unit, plus three (3) months supplies, conductive garment x two (2) purchase:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrical nerve stimulation (TENS).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 114-121.

**Decision rationale:** The California MTUS Guidelines state transcutaneous electrotherapy is not recommended as a primary treatment modality, but a 1 month home-based trial may be considered as noninvasive conservative option. A form-fitting device is only considered medically necessary when there is documentation of a large area that requires stimulation that a conventional system cannot accommodate. There is no documentation of a contraindication to a conventional system as opposed to a form-fitting device. There is also no documentation of a successful 1 month trial prior to the request for a unit purchase. As such, the request is not medically appropriate.

**MRI of the cervical spine:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-179.

**Decision rationale:** The California MTUS/ACOEM Practice Guidelines state for most patients presenting with true neck or upper back problems, special studies are not needed unless a 3 to 4 week period of conservative care and observation fails to improve symptoms. There is no documentation of a significant musculoskeletal or neurological deficit upon physical examination that would warrant the need for an MRI of the cervical spine. There is no evidence of tissue insult or nerve impairment. Therefore, the request is not medically appropriate.

**MRI of the thoracic spine:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-305.

**Decision rationale:** The California MTUS/ACOEM Practice Guidelines state if physiologic evidence indicates tissue insult or nerve impairment, the practitioner can discuss with a consultant the selection of an imaging test. There was no documentation of a significant musculoskeletal or neurological deficit upon physical examination. There is no evidence of tissue insult or nerve impairment. Therefore, the medical necessity has not been established. As such, the request is not medically appropriate.

**Flurbiprofen 20% cream 120gm, to be applied on the affected area two to three (2-3) times a day as directed by physician:** Upheld

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

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

**Decision rationale:** The California MTUS Guidelines state topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. Any compounded product that contains at least 1 drug (or drug class) that is not recommended, is not recommended as a whole. The only FDA-approved topical NSAID is diclofenac. Therefore, the current request is not medically appropriate.

**Ketoprofen 20%, Ketamine 10% cream 120gm, to be applied on the affected area two to three times a day as directed by physician:** Upheld

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

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

**Decision rationale:** The California MTUS Guidelines state topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. Any compounded product that contains at least 1 drug (or drug class) that is not recommended, is not recommended as a whole. The only FDA-approved topical NSAID is diclofenac. Therefore, the current request is not medically appropriate.

**Gabapentin 10%, Cyclobenzaprine 10 %, Capsacin 0.0375% cream 120gm to be applied on the affected atrea two to three (2-3) times a day as directed by physician: Upheld**

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

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

**Decision rationale:** The California MTUS Guidelines state topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. Any compounded product that contains at least 1 drug (or drug class) that is not recommended, is not recommended as a whole. Gabapentin is not recommended as there is no peer-reviewed literature to support its use. Muscle relaxants are also not recommended as a topical product. Therefore, the request is not medically appropriate.