

Case Number:	CM14-0087050		
Date Assigned:	07/23/2014	Date of Injury:	09/09/2008
Decision Date:	08/18/2015	UR Denial Date:	05/24/2014
Priority:	Standard	Application Received:	06/10/2014

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. 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: Iowa, Illinois, Hawaii

Certification(s)/Specialty: Preventive Medicine, Occupational Medicine, Public Health & General Preventive 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 50 year old female who sustained an industrial injury on 9/9/08. The injured worker was diagnosed as having lumbar disc disease with intermittent evidence of radiculopathy. Currently, the injured worker was with complaints of back pain with radicular symptoms in the lower extremities. Previous treatments included nerve block, exercise, and heat/ice application and medication management. Previous diagnostic studies included a magnetic resonance imaging. Physical examination was notable for lumbar decreased flexion, axial back pain and lower extremity back pain. The plan of care was for radiofrequency ablation, medication prescriptions and aqua therapy machine.

IMR ISSUES, DECISIONS AND RATIONALES

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

Medrox patches #5 boxes: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines topical medications.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Compound creams.

Decision rationale: The Medrox patches contain topical menthol, capsaicin, and salicylate. ODG recommends usage of topical analgesics as an option, but also further details "primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed." The medical documents do not indicate failure of antidepressants or anticonvulsants. MTUS states, "There is little to no research to support the use of many of these agents. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended." MTUS recommends topical capsaicin "only as an option in patients who have not responded or are intolerant to other treatments." There is no indication that the patient has failed oral medication or is intolerant to other treatments. ODG only comments on menthol in the context of cryotherapy for acute pain, but does state "Topical OTC pain relievers that contain menthol, methyl salicylate, or capsaicin, may in rare instances cause serious burns, a new alert from the FDA warns." MTUS states regarding topical Salicylate, "Recommended. Topical salicylate (e.g., Ben-Gay, methyl salicylate) is significantly better than placebo in chronic pain. (Mason-BMJ, 2004) See also Topical analgesics; & Topical analgesics, compounded." In this case, topical capsaicin is not supported for topical use per guidelines. As such, the request for Medrox patches #5 boxes is not medically necessary.

Right L3, L4, L5 and S1 radiofrequency ablation under fluoroscopic guidance: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 287-315. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back - Lumbar & Thoracic (Acute & Chronic), Facet joint radiofrequency neurotomy.

Decision rationale: ODG states, "Criteria for use of facet joint radiofrequency neurotomy: (1) Treatment requires a diagnosis of facet joint pain using a medial branch block as described above. See Facet joint diagnostic blocks (injections). (2) While repeat neurotomies may be required, they should not occur at an interval of less than 6 months from the first procedure. A neurotomy should not be repeated unless duration of relief from the first procedure is documented for at least 12 weeks at 50% relief. The current literature does not support that the procedure is successful without sustained pain relief (generally of at least 6 months duration). No more than 3 procedures should be performed in a year's period. (3) Approval of repeat neurotomies depends on variables such as evidence of adequate diagnostic blocks, documented improvement in VAS score, decreased medications and documented improvement in function. (4) No more than two joint levels are to be performed at one time. (5) If different regions require neural blockade, these should be performed at intervals of no sooner than one week, and preferably 2 weeks for most blocks. (6) There should be evidence of a formal plan of additional evidence-based conservative care in addition to facet joint therapy." Medical records indicate the patient received bilateral facet joint injections, L3-4 and L4-5 in 2013 resulting in an improvement in pain levels for only 2 weeks. Guidelines do not support that the procedure is successful

without sustained pain relief (generally of at least 6 months duration). As such, the request for Right L3, L4, L5 and S1 radiofrequency ablation under fluoroscopic guidance is not medically necessary.

Medrox ointment #2 bottles: 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 based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Compound creams.

Decision rationale: The Medrox patches contain topical menthol, capsaicin, and salicylate. ODG recommends usage of topical analgesics as an option, but also further details "primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed." The medical documents do not indicate failure of antidepressants or anticonvulsants. MTUS states, "There is little to no research to support the use of many of these agents. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended." MTUS recommends topical capsaicin "only as an option in patients who have not responded or are intolerant to other treatments." There is no indication that the patient has failed oral medication or is intolerant to other treatments. ODG only comments on menthol in the context of cryotherapy for acute pain, but does state "Topical OTC pain relievers that contain menthol, methyl salicylate, or capsaicin, may in rare instances cause serious burns, a new alert from the FDA warns." MTUS states regarding topical Salicylate, "Recommended. Topical salicylate (e.g., Ben-Gay, methyl salicylate) is significantly better than placebo in chronic pain. (Mason-BMJ, 2004) See also Topical analgesics; & Topical analgesics, compounded." In this case, topical capsaicin is not supported for topical use per guidelines. As such, the request for Medrox ointment #2 bottles is not medically necessary.

1 aqua therapy machine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 333-796.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back (Lumbar and Thoracic), Lumbar Support and Other Medical Treatment Guidelines <http://www.deroyal.com/medicalproducts/orthopedics/product.aspx?id=pc-temphtherapy-coldtherunit>.

Decision rationale: MTUS is silent on the use of cold therapy units. ODG for heat/cold packs states "Recommended as an option for acute pain. At-home local applications of cold packs in first few days of acute complaint; thereafter, applications of heat packs or cold packs. (Bigos, 1999) (Airaksinen, 2003) (Bleakley, 2004) (Hubbard, 2004) Continuous low-level heat wrap therapy is superior to both acetaminophen and ibuprofen for treating low back pain. (Nadler

2003) The evidence for the application of cold treatment to low-back pain is more limited than heat therapy, with only three poor quality studies located that support its use, but studies confirm that it may be a low risk low cost option. (French-Cochrane, 2006) There is minimal evidence supporting the use of cold therapy, but heat therapy has been found to be helpful for pain reduction and return to normal function. (Kinkade, 2007)" The use of devices that continually circulate a cooled solution via a refrigeration machine have not been shown to provide a significant benefit over ice packs. As such, the request for 1 aqua therapy machine is not medically necessary.