

Case Number:	CM15-0004857		
Date Assigned:	01/16/2015	Date of Injury:	01/22/2013
Decision Date:	03/18/2015	UR Denial Date:	12/19/2014
Priority:	Standard	Application Received:	01/09/2015

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, Hawaii
 Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 53 year old female, who sustained an industrial injury on January 22, 2013. The mechanism of injury is unknown. The diagnoses have included cervical musculoligamentous sprain/strain with right upper extremity radiculitis and three millimeter disc protrusion at C6-7, lumbar musculoligamentous sprain/strain with 3-4 millimeter disc protrusion and stenosis at L2-3 and right shoulder sprain/strain with partial tear of the supraspinatus tendon. Treatment to date has included diagnostic studies, lumbar spine traction, chiropractic sessions, home exercise program and medications. Currently, the injured worker complains of occasional symptoms in her right shoulder and ongoing low back pain. She reported that the lumbar spine traction did not help. She declined a pain management consultation in consideration for injections. On December 19, 2014, Utilization Review non-certified Ultracin Topical Lotion #120 milliliters and an H-Wave Homecare System, noting the California Chronic Pain Medical Treatment Guidelines. On January 6, 2015, the injured worker submitted an application for Independent Medical Review for review of Ultracin Topical Lotion #120 milliliters and an H-Wave Homecare System.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 Prescription For Ultracin Topical Lotion #120ml (Through Express Scripts 800-945-5951): 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 rationale: The patient presents with pain affecting the right shoulder and low back. The current request is for 1 Prescription For Ultracin Topical Lotion #120ml (Through Express Scripts 800-945-5951). The requesting treating physician report was not found in the documents provided. The most current report provided for review was dated 1/14/14 (5). The UR report dated 12/19/14 (27) does not provide a rationale from the treating physician for the current request. Ultracin is a compounded product that contains capsaicin, salicylates, and menthol. The MTUS has the following regarding topical analgesics: Largely experimental in use with few randomized controlled trials to determine efficacy or safety. Primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. It is unclear how long the patient has been using Ultracin topical lotion. In this case, there is no documentation of the efficacy of this medication in the reports provided. Furthermore, there is no evidence of failed trials of antidepressants and anticonvulsants and topical NSAIDs are only to be used for peripheral joint arthritic pain, which this patient does not present with. The current request is not medically necessary and the recommendation is for denial.

1 H-Wave Homecare System (Through [REDACTED]): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines H-Wave Page(s): 117.

Decision rationale: The patient presents with pain affecting the right shoulder and low back. The current request is 1 H-Wave Homecare System ([REDACTED]). The requesting treating physician report was not found in the documents provided. The most current report provided for review was dated 1/14/14 (5). The UR report dated 12/19/14 (27) does not provide a rationale from the treating physician for the current request either. The UR report does mention that the patient was recently approved for physical therapy. The MTUS Guidelines state, H-wave is not recommended as an isolated intervention, but a 1-month home-based trial of H-wave stimulation may be considered as a non-invasive conservative option for diabetic, neuropathic pain, or chronic soft tissue inflammation if used as an adjunct to a program of evidence-based functional restoration and only following failure of initially recommended conservative care including recommended physical therapy (i.e., exercise) and medications, plus transcutaneous electrical nerve stimulation (TENS). MTUS further states "trial periods of more than 1 month should be justified by documentations submitted for review." In this case, there is no documentation of a failed trial of medications, physical therapy (was just authorized per UR

report dated 12/19/14) or a TENS unit in the reports provided. Furthermore, there is no evidence of a previous 1 month H-Wave trial to support a request for purchase of a homecare system. The current request does not satisfy the MTUS guidelines as outlined on pages 117-118. Recommendation is for denial.