

Case Number:	CM15-0017280		
Date Assigned:	02/05/2015	Date of Injury:	02/23/2009
Decision Date:	03/30/2015	UR Denial Date:	01/15/2015
Priority:	Standard	Application Received:	01/29/2015

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

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 was a 54 year old female, who sustained an industrial injury, February 23, 2009. The injured worker was injured when pulling a walker out of the car when the injured worker was struck by a car in the right buttocks, pressing the injured worker against the car and pushing the injured car ahead 2-3 feet. The injured worker sustained injuries to the thoracic, lumbar and sacral areas of the back. According to progress note of January 5, 2015, the injured workers chief complaint was low back pain 6 out of 10; 0 being no pain and 10 being the worse pain. According to the Progress note of October 26, 2014, the injured workers pain was from coccyx, lower back and thoracic spine. The physical exam noted tenderness in the entire spine thoracic, cervical, lumbar and tenderness at S1. The injured worker had tenderness with spasms of L3-L5 paraspinal muscles and decreased range of motion. There was increased pain with bending 5 degrees, 5 degree rotation and extension of the back localizing to the lumbar facet joints of bilateral L4-S1. The injured worker has decreased sensory at the L4, L5 and S1 distribution. The injured worker uses a wheeled walker for ambulation. The injured worker was diagnosed lumbar disc herniation and tears to the spinal cord, random drug screening, radiculopathy and chronic back pain. The injured worker previously received the following treatments surgery and removal of crushed coccyx on August 2011, wheeled walker for ambulation, Ketoprofen cream for the lower back, Cyclobenzaprine for spasms and pain medication. On October 26, 2014, the primary treating physician requested authorization for Ketoprofen cream 20% #2 tubes and TENS (transcutaneous electrical nerve stimulator) unit supplies. The documentation submitted for review did not support the injured worker was using a

TENS (transcutaneous electrical nerve stimulator) unit. On January 15, 2015, the UR denied authorization for Ketoprofen cream 20% #2 tubes and TENS (transcutaneous electrical nerve stimulator) unit supplies. The denial was based on the MTUS/ACOEM and ODG guidelines.

IMR ISSUES, DECISIONS AND RATIONALES

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

Ketoprofen cream 20% #2 tubes: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113.

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

Decision rationale: Per the report of 01/05/15 the patient presents with lower back pain. The 10/26/14 report states the patient complains of pain from the lower back, thoracic spine and coccyx. The current request is for KETOPROFEN CREAM 20% #2 TUBES. The RFA is not included. The patient is disabled. MTUS Topical Analgesics guidelines pages 111 and 112 has the following regarding topical creams, "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 further states, "Non FDA-approved agents: Ketoprofen: This agent is not currently FDA approved for a topical application. It has an extremely high incidence of photocontact dermatitis." The 10/26/14 report states this medication is for treatment of lower back pain to avoid additional oral medications. The treater states on 01/05/15 that the patient finds this cream helpful and she receives immediate pain relief. In this case, however, the requested compounded cream contains Ketoprofen which guidelines state is not currently FDA approved for topical application. Therefore, the requested medication is not recommended, and this request IS NOT medically necessary.

Purchase of TENS unit supplies: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrotherapy - Criteria for the use of TENS Page(s): 114-116.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS, chronic pain (transcutaneous electrical nerve stimulation) Page(s): 114-116.

Decision rationale: Per the report of 01/05/15 the patient presents with lower back pain. The 10/26/14 report states the patient complains of pain from the lower back, thoracic spine and coccyx. The current request is for PURCHASE OF TENS UNIT SUPPLIES. The RFA is not included. The patient is disabled. MTUS, TENS, chronic pain (transcutaneous electrical nerve stimulation) (p114-116) states, "Not recommended as a primary treatment modality, but a one-month home-based TENS trial may be considered as a noninvasive conservative option, if used as an adjunct to a program of evidence-based functional restoration, for the conditions described below. MTUS further states use is for neuropathic pain." The patient's treatment history is limited

as only two medical reports are provided for review. TENS is indicated for the neuropathic pain that is documented for this patient. It does not appear that this is a primary treatment modality as the patient is prescribed medications that include Baclofen and Topiramate. However, the reports provided do not discuss TENS. The treater does not explain when TENS treatment started, how the unit is used, and if and/or how the unit decreases pain or increases function. In this case, the request IS NOT medically necessary.