MAXIMUS Federal Services

Case Number:	CM15-0123282		
Date Assigned:	07/07/2015	Date of Injury:	09/07/2011
Decision Date:	08/04/2015	UR Denial Date:	06/02/2015
Priority:	Standard	Application Received:	06/26/2015

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: 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 42 year old male, who sustained an industrial injury on 09/07/2011. He has reported injury to the low back. The diagnoses have included lumbar sprain/strain; lumbar intervertebral disc disorder with myelopathy; status post failed lumbar epidural x 3; and lumbar disc bulge with right leg radiculopathy. Treatment to date has included medications, diagnostics, acupuncture, epidural steroid injections, physical therapy, and home exercise program. Medications have included Naproxen and Omeprazole. A progress note from the treating physician, dated 05/27/2015, documented a follow-up visit with the injured worker. Currently, the injured worker complains of a flare up of lower back pain that radiates to the right leg; pain is rated at 7-8/10 on the pain scale; no change since last visit; still has intermittent right leg radiculopathy symptoms; the symptoms are constant, but worsen with lying flat, sitting, and driving; he has failed three lumbar epidurals; and he has seen a spine surgeon and is pending surgery. Objective findings included palpable tenderness at the left lumbar, lumbar, right sacroiliac, right lumbar, left sacroiliac, sacral, right buttock, right posterior leg, right posterior thigh, and calf; tenderness at paraspinal muscles with spasms; decreased range of motion of the lumbar spine; and EMG (electromyography) reveals L4/L5 radiculopathy on the right. The treatment plan has included the request for Flurbiprofen 20%/Baclofen 2%/Dexamethasone 2%/Menthol 2%/Camphor 2%/Capsaicin 0.0375% /Hyaluronic acid 0.20% 180g; and interferential unit for 1 month.

IMR ISSUES, DECISIONS AND RATIONALES

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

Flurbiprofen 20%/Baclofen 2%/Dexamethasone 2%/Menthol 2%/Camphor 2%/Capsaicin 0.0375/Hyaluronic acid 0.20% 180g: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics, Non-steroidal anti-inflammatory agents, Capsaicin, Baclofen Page(s): 111-113. Decision based on Non-MTUS Citation www.ncbi.nlm.nih.gov/pubmed/15857456.

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: MTUS and 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 states that topical Baclofen is not recommended. MTUS states that the only FDA- approved NSAID medication for topical use includes diclofenac, which is indicated for relief of osteoarthritis pain in joints. Flurbiprofen would not be indicated for topical use in this case. As such, the request for Flurbiprofen 20%/Baclofen 2%/Dexamethasone 2%/Menthol 2%/Camphor 2%/Capsaicin 0.0375/Hyaluronic acid 0.20% 180g is not medically necessary.

Interferential unit for 1 month: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential current stimulation Page(s): 120.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 287-315, Chronic Pain Treatment Guidelines Interferential Current Stimulation, Transcutaneous electrotherapy Page(s): 54, 114-116, 118-120.

Decision rationale: ACOEM guidelines state: insufficient evidence exists to determine the effectiveness of sympathetic therapy, a noninvasive treatment involving electrical stimulation, also known as interferential therapy. At-home local applications of heat or cold are as effective as those performed by therapists. MTUS further states regarding interferential units: not recommended as an isolated intervention and details the criteria for selection: Pain is ineffectively controlled due to diminished effectiveness of medications; or Pain is ineffectively controlled with medications due to side effects; or History of substance abuse; or Significant pain from postoperative conditions limits the ability to perform exercise programs/ physical therapy treatment; or Unresponsive to conservative measures (e.g., repositioning, heat/ice, etc.). If those criteria are met, then a one-month trial may be appropriate to permit the physician and physical medicine provider to study the effects and benefits. The medical documentation

provided indicate this patient has had unresponsiveness to conservative measures such as repositioning, heat/ice, etc., as well as continued pain despite medication therapy. The medical documents do indicate ongoing home exercise program. The request falls within guidelines for a one month home trial. As such, the request for Interferential unit for 1 month is medically necessary.