

Case Number:	CM15-0128021		
Date Assigned:	07/14/2015	Date of Injury:	09/07/2011
Decision Date:	08/13/2015	UR Denial Date:	06/08/2015
Priority:	Standard	Application Received:	07/02/2015

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, Pain Management

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 with an industrial injury dated 09/07/2011. The injury is documented as occurring when he was moving boxes of automobile parts weighting up to 60 pounds causing low back pain. His diagnoses included lumbosacral radiculopathy, lumbar sprain/strain and right leg radiculitis. Comorbid condition was kidney disease. Prior treatment included acupuncture, physical therapy, lumbar epidural injections, diagnostics, chiropractor evaluation, psych evaluation and medications. He presents on 05/27/2015 with flare up of lower back pain rated as 7-8/10 with radiation to the right leg with no changes since last visit. The provider documents the injured worker is pending surgery and has failed three lumbar spine epidural injections. He continued to have intermittent right leg radiculopathy symptoms. Physical exam noted palpable tenderness at left lumbar, right sacroiliac, right lumbar, left sacroiliac, sacral, right buttock, right posterior leg, thigh and calf. There was tenderness at paraspinal muscles with spasm. Lumbar range of motion was decreased. MRI is documented by provider as showing 4 mm disc, right paracentral abutting the right exiting nerve root with annular fissure at lumbar 4/5. Nerve conduction studies (as documented by provider) revealed lumbar 4-5 radiculopathy on the right. Treatment included physiotherapy of the lumbar spine, pain cream and interferential unit. He last worked in late September 2011. The request for follow up with spine surgeon for surgery was authorized. The treatment request for review is FCL (Flurbiprofen 20%, Baclofen 2 %, Dexamethasone 2 %, Menthol 2 %, Camphor 2 %, Capsaicin 0.0375%, and Hyaluronic Acid 0.20%) 180 grams, interferential unit, rental 1 month and physiotherapy 2 times a week for 3 weeks for a total of 6 visits.

IMR ISSUES, DECISIONS AND RATIONALES

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

FCL 180 grams: 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 of 127.

Decision rationale: Regarding the request for FCL, CA MTUS states that topical compound medications require guideline support for all components of the compound in order for the compound to be approved. Topical NSAIDs are indicated for "Osteoarthritis and tendinitis, in particular, that of the knee and elbow or other joints that are amenable to topical treatment: Recommended for short-term use (4-12 weeks). There is little evidence to utilize topical NSAIDs for treatment of osteoarthritis of the spine, hip or shoulder. Neuropathic pain: Not recommended as there is no evidence to support use". Capsaicin is "Recommended only as an option in patients who have not responded or are intolerant to other treatments". Baclofen is not supported by the CA MTUS for topical use. Within the documentation available for review, none of the abovementioned criteria have been documented. Furthermore, there is no clear rationale for the use of topical medications rather than the FDA-approved oral forms for this patient. Given all of the above, the requested FCL is not medically necessary.

Physiotherapy 2 times a week for 3 weeks for a total of 6 visits: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 98-99 of 127. Decision based on Non-MTUS Citation ODG, Low Back Chapter, Physical Medicine.

Decision rationale: Regarding the request for physical therapy, Chronic Pain Medical Treatment Guidelines recommend a short course (10 sessions) of active therapy with continuation of active therapies at home as an extension of the treatment process in order to maintain improvement levels. ODG has more specific criteria for the ongoing use of physical therapy. ODG recommends a trial of physical therapy. If the trial of physical therapy results in objective functional improvement, as well as ongoing objective treatment goals, then additional therapy may be considered. Within the documentation available for review, there is no documentation of specific objective functional improvement with any previous sessions and remaining deficits that cannot be addressed within the context of an independent home exercise program yet are expected to improve with formal supervised therapy. In light of the above issues, the currently requested physical therapy is not medically necessary.

Interferential unit, rental 1 month: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 118-120 of 127.

Decision rationale: Regarding the request for interferential unit, CA MTUS Chronic Pain Medical Treatment Guidelines state that interferential current stimulation is not recommended as an isolated intervention. They go on to state that patient selection criteria if interferential stimulation is to be used anyways include pain is ineffectively controlled due to diminished effectiveness of medication, side effects or history of substance abuse, significant pain from postoperative conditions limits the ability to perform exercises, or unresponsive to conservative treatment. If those criteria are met, then in one month trial may be appropriate to study the effects and benefits. With identification of objective functional improvement, additional interferential unit use may be supported. Within the documentation available for review, there is no indication that the patient has met the selection criteria for interferential stimulation as outlined above. In light of the above issues, the currently requested interferential unit is not medically necessary.