MAXIMUS Federal Services

Case Number:	CM15-0174659		
Date Assigned:	09/16/2015	Date of Injury:	12/08/1996
Decision Date:	10/21/2015	UR Denial Date:	08/17/2015
Priority:	Standard	Application Received:	09/04/2015

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 is a 69 year old male, who sustained an industrial injury on December 8, 1996. The injured worker was diagnosed as having post-op second L5-S1 (lumbar 5-sacral 1) microdiscectomy in 2009 and chronic lumbar pain. Medical records (April 15, 2014 to August 11, 2014) indicate ongoing neck and low back pain radiating to the right lower extremity. On August 11, 2014, the injured worker reported a flare-up of his chronic low back pain. Associated symptoms include stiffness and limited range of motion. His reported his pain medications were working well. His current pain level was moderate, but controlled for the low back pain. The physical exam revealed lumbar spine range of motion was 30% of normal. There was 1+ bilateral knee jerk, an absent left ankle jerk, a trace right ankle jerk, no lower extremity motor deficit, and sensory deficit of the right leg L5 and S1 dermatomes. The treatment plan included Voltaren 1%, and a TENS (transcutaneous electrical nerve stimulation) unit. Diagnostic studies to date have included a MRI of the lumbar spine in 2011. Treatment has included a home exercise program and medications including oral pain (Tramadol since at least February 2013), topical pain (Flector patch since at least April 2014) muscle relaxant (Tizanidine since at least February 2013), and proton pump inhibitor (omeprazole since at least October 2011). On August 17, 2015, the original utilization review non-certified a request Voltaren 1%, 20gm, with refills times 3 and partially approved a request for a TENS (transcutaneous electrical nerve stimulation) unit for a 30-day home trial (original request was a rental for 3 months).

IMR ISSUES, DECISIONS AND RATIONALES

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

Voltaren 1%, 20gm, with refills times 3: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Topical Analgesics.

Decision rationale: The patient presents with pain in the low back and the neck. The request is for VOLTAREN 1% 20GM, WITH REFILLS TIMES 3. Examination to the lumbar spine on 07/15/15 revealed decreased range of motion in all planes. Per 08/11/15 progress report, patient's diagnosis include post-op second L5-S1 microdiscectomy, chronic lumbar pain, CAD/post C.A.B.G (Non-Industrial), sacroidosis (Non-Industrial), pyloric cyst (Non-Industrial) and post C.A.B.G./post stent replacement. Patient's medications, per 04/15/15 progress report include Tizanidine, Tramadol, and Flector Patch. Patient's work status was not specified. MTUS Chronic Pain Medical Treatment Guidelines 2009, Topical Analgesics section, under Non-steroidal anti-inflammatory agents, page 111-112 has the following: "The efficacy in clinical trials for this treatment modality has been inconsistent and most studies are small and of short duration. Topical NSAIDs have been shown in meta-analysis to be superior to placebo during the first 2 weeks of treatment for osteoarthritis, but either not afterward, or with a diminishing effect over another 2-week period." "...this class in general is only recommended for relief of osteoarthritis pain in joints that lend themselves to topical treatment (ankle, elbow, foot, hand, knee, and wrist)." Voltaren Gel 1% (diclofenac): Indicated for relief of osteoarthritis pain in joints that lend themselves to topical treatment (ankle, elbow, foot, hand, knee, and wrist). It has not been evaluated for treatment of the spine, hip or shoulder." A prescription for Voltaren 1% Gel first appears in progress report dated 08/11/15. Review of the medical records provided does not indicate prior use of this medication and it appears that the treater is initiating this medication. The patient continues with pain in the low back and the neck. MTUS guidelines do not support the use of topical NSAIDs for axial pain. Furthermore, the guidelines recommend short term use of topical NSAIDs, due to diminishing effects lasting less than 4 weeks, and the requested 3 tubes exceeds guideline recommendations. Therefore, the request IS NOT medically necessary.

TENS (transcutaneous electrical nerve stimulation) unit rental times 3 months: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Transcutaneous electrotherapy.

Decision rationale: The patient presents with pain in the low back and the neck. The request is for TENS (transcutaneous electrical nerve stimulation) unit rental times 3 months. Examination to the lumbar spine on 07/15/15 revealed decreased range of motion in all planes. Per 08/11/15 progress report, patient's diagnosis include post-op second L5-S1 microdiscectomy, chronic

lumbar pain, CAD/post C.A.B.G (Non-Industrial), sacroidosis (Non-Industrial), pyloric cyst (Non-Industrial) and post C.A.B.G./post stent replacement. Patient’s medications, per 04/15/15 progress report include Tizanidine, Tramadol, and Flector Patch. Patient's work status was not specified. MTUS Chronic Pain Medical Treatment Guidelines 2009, TENS, Chronic Pain (Transcutaneous Electrical Nerve Stimulation) section, page 114 to 116 require the following: "(1) Documentation of pain of at least three months duration (2) There is evidence that other appropriate pain modalities have been tried (including medication) and failed. (3) A one-month trial period of the TENS unit should be documented (as an adjunct to ongoing treatment modalities within a functional restoration approach) with documentation of how often the unit was used, as well as outcomes in terms of pain relief and function; rental would be preferred over purchase during this trial. (4) Other ongoing pain treatment should also be documented during the trial period including medication usage (5) A treatment plan including the specific short- and long-term goals of treatment with the Tens unit should be submitted (6) A 2-lead unit is generally recommended; if a 4-lead unit is recommended, MTUS recommends TENS for neuropathic pain, CRPS, Multiple Sclerosis, Phantom pain, and spasticity pain." In progress report dated 08/11/15, the treater is requesting a TENS unit trial for 3 months for flaring back and neck pain. Review of the medical records provided did not indicate a prior one-month trial and its outcome, and there is no treatment plan with short and long-term goals. MTUS requires documentation of one month prior to dispensing home units, as an adjunct to other treatment modalities, with a functional restoration approach. Given the lack of documentation, as required by MTUS, the request IS NOT medically necessary.