

Case Number:	CM15-0020287		
Date Assigned:	02/20/2015	Date of Injury:	08/14/2000
Decision Date:	06/08/2015	UR Denial Date:	01/09/2015
Priority:	Standard	Application Received:	02/03/2015

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: New York
 Certification(s)/Specialty: Internal 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 63 year old female injured worker suffered and industrial injury on 8/14/2000. The diagnoses were cervicgia, lumbago and pain in the thoracic spine. The treatments were chiropractic therapy and medications. The treating provider reported pain in the cervical spine as 3/10, thoracic pain 7/10 and lumbar pain as 5/10. The lumbar pain radiated to the left lower extremity with tenderness to the cervical and lumbar spine along with headaches. The Utilization Review Determination on 1/9/2015 non-certified: 1. IF or muscle stimulation/ conductive garments, MTUS, ACOEM; 2. Cervical traction unit with air bag, ODG; 3. Lumbar support and back support, MTUS, ACOEM; 4. Lidopro Cream 1 bottle, MTUS; 5. Terocin Patches #30, MTUS; 6. Chiropractic therapy x 9 sessions for lumbar spine, MTUS.

IMR ISSUES, DECISIONS AND RATIONALES

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

IF or muscle stim/ conductive garments: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chronic Pain Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrotherapy, Interferential Current Stimulation (ICS) Page(s): 118.

Decision rationale: MTUS states that Interferential Current Stimulation is not recommended as isolated modality. There is very little evidence to show it is superior to standard Transcutaneous Electrical Nerve Stimulation (TENS). Electrotherapy is recommended in conjunction with other treatments, including return to work, exercise and medications. This form of treatment is appropriate for patients with significant pain from postoperative conditions that limit the ability to perform exercise programs/physical therapy treatment, or refractory to conservative measures (e.g., repositioning, heat/ice, etc.), patients whose pain is ineffectively controlled due to diminished effectiveness or side effects of medications or patients with history of substance abuse. 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. There should be evidence of increased functional improvement, less reported pain and evidence of medication reduction. A "jacket" should not be certified until after the one-month trial and only with documentation that the individual cannot apply the stimulation pads alone or with the help of another available person. Documentation provided does not support that the injured worker is physically limited from a postoperative condition or participating in other recommended treatments, including a home exercise program. With MTUS criteria not being met, the medical necessity for an interferential unit has not been established. Subsequently, the request for IF or muscle stim/ conductive garments is not medically necessary.

Cervical traction unit with air bag: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines- Neck and Upper Back Chapter.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): Initial Assessment, pg 173.

Decision rationale: Per MTUS, there is no high-grade scientific evidence to support the effectiveness or ineffectiveness for the use of passive physical modalities such as traction for the treatment of neck pain. The injured worker complains of chronic neck pain. Documentation provided does not show objective evidence of radicular symptoms and there is no report of prescribed home exercise program at the time of the request under review. The request for Cervical traction unit with air bag is not medically necessary by MTUS.

Lumbar support and back support: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 301.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): Initial Care, pg 301. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, Lumbar supports.

Decision rationale: MTUS states that the use of Lumbar supports to treat low back pain has not been shown to have any lasting benefit beyond the acute phase of symptom relief. Per guidelines, lumbar supports may be recommended as an option for compression fractures and specific treatment of spondylolisthesis and documented instability. Long-term use of lumbar supports is not recommended. Chart documentation shows the injured worker complains of chronic low back pain and there is no report of acute exacerbation of symptoms to justify the use of a lumbar support. The request for Lumbar support and back support is not medically necessary.

Lidopro Cream 1 bottle: 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.

Decision rationale: MTUS states that use of topical analgesics is primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. There is little to no research to support the use of many of these agents. Lidopro is a topical analgesic containing capsaicin, lidocaine, menthol, and methyl salicylate. MTUS provides no evidence recommending the use of topical Menthol. Other than the dermal patch (Lidoderm), no other commercially approved topical formulation of lidocaine, including creams, lotions or gels, are indicated for the treatment of neuropathic pain. Per guidelines, any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. The request for Lidopro Cream 1 bottle is not medically necessary.

Terocin Patches #30: 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.

Decision rationale: MTUS states that use of topical analgesics is primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. There is little to no research to support the use of many of these agents. Terocin is a topical analgesic containing Lidocaine and Menthol. MTUS provides no evidence recommending the use of topical Menthol. Per guidelines, any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. The request for Terocin Patches #30 is not medically necessary by MTUS.

Chiropractic therapy x 9 sessions for lumbar spine: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy & Manipulation.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy & manipulation Page(s): 58. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter.

Decision rationale: MTUS recommends a trial of 6 Chiropractic visits over 2 weeks for initial treatment of low back pain. With evidence of objective functional improvement, a total of up to 18 visits over 6-8 weeks may be prescribed. Per MTUS, elective/maintenance care is not medically necessary. Documentation reveals that the injured worker has had 6 Chiropractic visits to date with reported improvement. Physician reports however fail to show evidence of objective functional improvement. Given that this injured worker has completed a course of Chiropractic therapy, which meets the quantity recommended by the MTUS and ODG as an initial course and the lack of physician reports describing specific functional improvement, the medical necessity for further Chiropractic therapy has not been established. The request for Chiropractic therapy x 9 sessions for lumbar spine is not medically necessary.