

Case Number:	CM15-0063425		
Date Assigned:	04/09/2015	Date of Injury:	02/12/2014
Decision Date:	05/15/2015	UR Denial Date:	03/19/2015
Priority:	Standard	Application Received:	04/03/2015

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: California

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 injured worker is a 59 year old male who sustained an industrial injury on 2/12/14. The injured worker reported symptoms in the back. The injured worker was diagnosed as having mild degenerative disc disease, generalized disc bulge and bilateral face hypertrophy, and possible contusion of the left L5 facet arthropathy at L5-S1. Treatments to date have included acupuncture treatment, chiropractic treatments, Lumbar-Sacral Orthosis, topical cream, oral analgesic, single point cane, and injections. Currently, the injured worker complains of mid to lower back pain with radiation to the lower extremities. The plan of care was for transcutaneous electrical nerve stimulation unit, medication prescriptions and a follow up appointment at a later date.

IMR ISSUES, DECISIONS AND RATIONALES

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

TENS (transcutaneous electrical nerve stimulator) Unit 30720,E0730: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrotherapy Page(s): 14-116.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300, 308-310, Chronic Pain Treatment Guidelines Transcutaneous electrotherapy Page 114-121. Electrical stimulators (E-stim) Page 45 Functional restoration programs (FRPs) Page 49.

Decision rationale: Medical Treatment Utilization Schedule (MTUS) addresses transcutaneous electrotherapy. MTUS Chronic Pain Medical Treatment Guidelines indicates that several published evidence-based assessments of transcutaneous electrical nerve stimulation (TENS) have found that evidence is lacking concerning effectiveness. American College of Occupational and Environmental Medicine (ACOEM) 2nd Edition (2004) Chapter 12 Low Back Complaints (Page 300) indicates that physical modalities such as diathermy, ultrasound, transcutaneous electrical neurostimulation (TENS) units, percutaneous electrical nerve stimulation (PENS) units, and biofeedback have no proven efficacy in treating acute low back symptoms. Insufficient scientific testing exists to determine the effectiveness of these therapies. Table 12-8 Summary of Recommendations for Evaluating and Managing Low Back Complaints (Page 308) indicates that TENS is not recommended. Medical records document low back complaints. MTUS and ACOEM guidelines do not support the use of transcutaneous electrical nerve stimulation (TENS) for low back conditions. Therefore, the request for TENS is not supported by MTUS or ACOEM guidelines. Therefore, the request for a TENS unit is not medically necessary.

Gabapentin 10% Cream, Qty 30: 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 Analgesics Page 111-113.

Decision rationale: Medical Treatment Utilization Schedule (MTUS) Chronic Pain Medical Treatment Guidelines address topical analgesics. Topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. There is little to no research to support the use of many of these agents. Gabapentin is not recommended. There is no peer-reviewed literature to support use. There is no evidence for use of any other antiepilepsy drug as a topical product. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Medical records document a history of low back complaints. MTUS guidelines do not support the use of topical products containing Gabapentin. Per MTUS, any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Therefore, the request for a topical product containing Gabapentin is not supported by MTUS. Therefore, the request for Gabapentin cream is not medically necessary.