

Case Number:	CM15-0099474		
Date Assigned:	06/01/2015	Date of Injury:	09/07/2011
Decision Date:	07/09/2015	UR Denial Date:	04/30/2015
Priority:	Standard	Application Received:	05/22/2015

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 42-year-old female, who sustained an industrial injury on 9/7/2011. She reported severe low back pain after moving heavy auto parts. The injured worker was diagnosed as having lumbar disc disorder with myelopathy, 3 failed epidural steroid injection, lumbar disc bulging and right leg radiculopathy. There is no record of a recent diagnostic study. Treatment to date has included epidural steroid injection, physiotherapy and medication management. In a progress note dated 4/23/2015, the injured worker complains of an acute flare of low back pain with radiation to the right leg. The treating physician is requesting 6 sessions of acupuncture for the lumbar spine, one month rental of an interferential unit and FCL pain cream 180 gm.

IMR ISSUES, DECISIONS AND RATIONALES

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

Acupuncture times 6 for lumbar spine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM, Acupuncture Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 9792. 24. 1. Acupuncture Medical Treatment Guidelines Page(s): 13.

Decision rationale: Based on the 04/23/15 progress report provided by treating physician, the patient presents with low back pain that radiates to right leg rated 7-8/10. The request is for ACUPUNCTURE TIMES 6 FOR LUMBAR SPINE. Patient's diagnosis per Request for Authorization form dated 04/23/15 and 05/27/15 includes lumbar IVD. Diagnosis on 04/23/15 included lumbar intervertebral disc disorder with myelopathy, and lumbar disc bulge with right leg radiculopathy. Physical examination to the lumbar spine on 04/23/15 revealed decreased range of motion in all planes. MRI of the lumbar spine, per 05/27/15 report revealed "4mm disc, right paracentral abutting the right exiting nerve root, with annular fissure at L4/5." Per 05/27/15 report, "EMG reveals L4-L5 radiculopathy on the right. The patient is status failed epidural x3. Treater states the patient is improving with physiotherapy. The patient is permanent and stationary, under Future Medical Care, per 04/23/15 report. Treater has not provided reason for the request. Per 04/23/15 report, treater states "Acupuncture helps with ADL, still waiting for authorization." In this case, a trial of acupuncture would be indicated given patient's symptoms and diagnosis. However, a precise treatment history has not been provided in medical records. Furthermore, MTUS requires documentation of functional improvement, defined by labor code 9792. 20(e) prior to extending additional treatments. The request for 6 additional sessions cannot be warranted given lack of documentation. Therefore, the request IS NOT medically necessary.

Interferential unit for 1 month: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation (ICS).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation Page(s): 118-120.

Decision rationale: Based on the 04/23/15 progress report provided by treating physician, the patient presents with low back pain that radiates to right leg rated 7-8/10. The request is for INTERFERENTIAL UNIT FOR 1 MONTH. Patient's diagnosis per Request for Authorization form dated 04/23/15 and 05/27/15 includes lumbar IVD. Diagnosis on 04/23/15 included lumbar intervertebral disc disorder with myelopathy, and lumbar disc bulge with right leg radiculopathy. Physical examination to the lumbar spine on 04/23/15 revealed decreased range of motion in all planes. MRI of the lumbar spine, per 05/27/15 report revealed "4mm disc, right paracentral abutting the right exiting nerve root, with annular fissure at L4/5." Per 05/27/15 report, "EMG reveals L4-L5 radiculopathy on the right. The patient is status failed epidural x3. Treater states the patient is improving with physiotherapy. The patient is permanent and stationary, under Future Medical Care, per 04/23/15 report. MTUS pages 118-120, under Interferential Current Stimulation has the following regarding ICS units: "While not recommended as an isolated intervention, Patient selection criteria if Interferential stimulation is to be used anyway: Possibly appropriate for the following conditions if it has documented and proven to be effective as directed or applied by the physician or a provider licensed to provide physical medicine. Pain is ineffectively controlled due to diminished effectiveness of medications. Pain is ineffectively controlled with medications due to side effects. History of substance abuse. Significant pain from postoperative conditions limits the ability to perform exercise programs/physical therapy treatment. 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. There should be evidence of increased functional improvement, less reported pain and evidence of medication reduction." Per 04/23/15 report, treater states "I prescribe the IF unit

for home use and pain relief purposes. " Treater has not indicated how the device will be used, or what body part will be treated. Medical records show the requested treatment is not intended as an isolated intervention, as the acupuncture is also being requested. With regards to interferential unit, there is no evidence that pain is not effectively controlled due to the effectiveness of medication, substance abuse or pain due to postoperative conditions or unresponsiveness to conservative measures. MTUS requires 30-day rental with documentation of use and efficacy before a home unit is allowed. There is no documentation that the patient has trialed IF unit for a one-month with documentation of outcomes. This request for Interferential unit home use for 1 month is not in accordance with guideline indications. Therefore, the request IS NOT medically necessary.

FCL pain cream 180gm: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Compounded Medications. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Chapter.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical analgesic Capsaicin, topical Page(s): 111-113, 29.

Decision rationale: Based on the 04/23/15 progress report provided by treating physician, the patient presents with low back pain that radiates to right leg rated 7-8/10. The request is for FCL PAIN CREAM 180GM. Patient's diagnosis per Request for Authorization form dated 04/23/15 and 05/27/15 includes lumbar IVD. Diagnosis on 04/23/15 included lumbar intervertebral disc disorder with myelopathy, and lumbar disc bulge with right leg radiculopathy. Physical examination to the lumbar spine on 04/23/15 revealed decreased range of motion in all planes. MRI of the lumbar spine, per 05/27/15 report revealed "4mm disc, right paracentral abutting the right exiting nerve root, with annular fissure at L4/5. " Per 05/27/15 report, "EMG reveals L4- L5 radiculopathy on the right. The patient is status failed epidural x3. Treater states the patient is improving with physiotherapy. The patient is permanent and stationary, under Future Medical Care, per 04/23/15 report. MTUS has the following regarding topical creams (p111, chronic pain section): "Topical Analgesics: Non-steroidal anti-inflammatory agents (NSAIDs): 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. Topical lidocaine, in the formulation of a dermal patch (Lidoderm) has been designated for orphan status by the FDA for neuropathic pain. Lidoderm is also used off-label for diabetic neuropathy. No other commercially approved topical formulations of lidocaine (whether creams, lotions or gels) are indicated for neuropathic pain. Gabapentin: Not recommended. Baclofen: Not recommended. Other muscle relaxants: There is no evidence for use of any other muscle relaxant as a topical product. MTUS, pg 29, Capsaicin, topical, " Indications: There are positive randomized studies with capsaicin cream in patients with osteoarthritis, fibromyalgia, and chronic non-specific back pain. Capsaicin is generally available as a 0.025% formulation (as a treatment for osteoarthritis) and a 0.075% formulation (primarily studied for post-herpetic neuralgia, diabetic neuropathy and post-mastectomy pain). There have been no studies of a 0.0375% formulation of capsaicin and there is no current indication that this increase over a 0.025% formulation would provide any further efficacy. Per 04/23/15 report, treater states "the patient was prescribed FCL (Flurbiprofen 20%, Baclofen 2%, Dexamethanoe 2%, Menthol 2%, Camphor 2%, Capsaicin 0.0375, Hyaluronic Acid 0.20% in 180 grams, to be applied to the affected area to reduce pain, increase function and mobility and decrease the need of additional

oral medications." However, MTUS page 111 states that if one of the compounded topical products is not recommended, then the entire product is not. In this case, the requested topical compound contains Baclofen, and Capsaicin 0.0375 which are not supported for topical use in lotion form. The request is not in accordance with guidelines. Therefore, the request IS NOT medically necessary.