

Case Number:	CM13-0029001		
Date Assigned:	06/06/2014	Date of Injury:	04/19/2012
Decision Date:	07/14/2014	UR Denial Date:	09/16/2013
Priority:	Standard	Application Received:	09/24/2013

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. The expert reviewer is Board Certified in Physical Medicine and Rehabilitation and is licensed to practice in Illinois. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 33-year-old male who reported an injury on 04/19/2012 due to a heavy lifting injury. The clinical note dated 10/18/2013 noted the injured worker presented with lower back pain and numbness in the right leg and the right anterior thigh, neck, and bilateral upper extremity numbness. Prior treatments included topiramate and tramadol. Upon exam of the cervical spine, the range of motion values were 45 degrees of extension, 30 degrees of flexion, and 60 degrees of rotation bilaterally. An x-ray of the cervical spine revealed cervical vertebrae with slight disc space narrowing at C5-6. The diagnoses were cervical strain and spondylosis, lumbar strain and spondylosis, and right L3-4 disc herniation and right sciatica. The provider recommended 1 cervical traction unit, topiramate, and Menthoderm gel. The Request for Authorization form was not included in the medical documents for review. The provider's rationale was not included.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 CERVICAL TRACTION UNIT: 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 (Acute and Chronic) Traction.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck and Upper Back, Traction.

Decision rationale: CA MTUS/ACOEM state that there is no high-grade scientific evidence to support the effectiveness or ineffectiveness of passive physical modalities such as traction, heat/cold applications, massage, diathermy, cutaneous laser treatment, ultrasound, transcutaneous electrical neurostimulation (TENS) units, and biofeedback. The Official Disability Guidelines further state that home cervical patient-controlled traction for injured workers with radicular symptoms, in conjunction with a home exercise program. Institutionally-based power traction devices are not recommended. There is limited documentation of efficacy of cervical traction beyond short-term pain reduction. In general, it would not be advisable to use these modalities beyond 2 to 3 weeks if signs of objective progress towards functional restoration are not demonstrated. In this case, the included medical documentation lacked evidence of current deficits to warrant the need for a cervical traction unit. The physical exam noted that the neurological exam of the upper extremities is within normal limits as sensation, motor strength, and deep tendon reflexes were within normal limits. The request as submitted failed to indicate whether the requested equipment was for rental or purchase. As such, the request for 1 cervical traction unit is not medically necessary.

1 PRESCRIPTION OF TOPIRAMATE 100 MG, #50: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antiepilepsy Drugs (AEDs).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-Epilepsy Drugs Page(s): 17.

Decision rationale: The California MTUS Guidelines note that topiramate has been shown to have valuable efficacy, with failure to demonstrate efficacy in neuropathic pain of central etiology. It is considered for use of neuropathic pain when other anticonvulsants fail. The injured worker has been prescribed topiramate since at least 04/2013. The medical documents lack evidence of efficacy of the medication as evidenced by decreased pain and increased function. There is a lack of evidence indicating the injured worker has significant findings to warrant the need for topiramate. The frequency of the medication was not provided in the request. As such, the request for 1 prescription of Topiramate 100mg #50 is not medically necessary.

1 PRESCRIPTION OF MENTHODERM GEL 120 GM: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Salicylates, and Menthol Topical.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111.

Decision rationale: California MTUS Guidelines state that transdermal compounds are largely experimental in use with few randomized control trials to determine efficacy or safety. Topical analgesic is primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Any compounded product that contains at least 1 drug that is not recommended is not recommended. Although the injured worker is currently taking that medication, the clinical documentation did not indicate it was not effective as the efficacy was not provided. The provider's request for Mentherm gel did not indicate a frequency or the site that the gel was intended for. As such, the request for 1 prescription of Mentherm gel, 120 gm, is not medically necessary.