

Case Number:	CM13-0035132		
Date Assigned:	12/13/2013	Date of Injury:	02/24/2012
Decision Date:	03/13/2014	UR Denial Date:	10/04/2013
Priority:	Standard	Application Received:	10/16/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician 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 physician 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 patient was a 65-year-old male who sustained an injury on 02/24/2012 when his vehicle stopped suddenly when a front wheel fell off resulting in him striking his head. The patient reported headache, confusion and low back pain following the injury. The patient was treated with 2 epidural steroid injections on 07/11/2012 and 08/31/2012 which was noted to only give him approximately a week of relief. Upon examination on 10/23/2013, the patient was found to have limited range of motion and tenderness unchanged from initial visit. The documentation submitted for review did not have objective findings to support the limited range of motion and tenderness. The treatment plan was noted as continue present care with Tramadol 15%/Dextromethorphan 10% creams and pending authorization of aqua therapy and H-wave. The documentation submitted for review indicated the patient had previously participated in a physical therapy program which did not help.

IMR ISSUES, DECISIONS AND RATIONALES

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

Tramadol 15% Dextromethorphan 10% Capsaicin 0.025%: Upheld

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

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

Decision rationale: The request for Tramadol 15%, Dextromethorphan 10%, and Capsaicin 0.025% is non-certified. The California MTUS Guidelines recommend the use of Capsaicin only as an option in patients who have not responded or are intolerant to other pain meds. The documentation submitted for review did not indicate the patient was intolerant of other treatments. It is further noted that the request includes the use of Tramadol 15%. The guidelines recommend the use of topical analgesics for neuropathic pain when trials of antidepressants and anticonvulsants have failed. There is no indication for the use of topical opioids versus an oral analgesic. As there was no indication as to the patient's need for a topical opioid versus an oral opioid, there is no supporting evidence as to the need and efficacy of the medication requested. Given the information submitted for review, the request for Tramadol 15%, Dextromethorphan 10%, and Capsaicin 0.025% is non-certified.

Home H-wave device: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines H-Wave Stimulation Section Page(s): 117.

Decision rationale: The request for a home H-wave device is non-certified. The California MTUS Guidelines recommend the use of an H-wave stimulation device not be an isolated treatment. There was an indication the patient was being requested for an adjunct treatment of aquatic therapy; however, given the patient previously had poor outcome from physical therapy, it is unclear if further therapy would be supported. In addition, the patient did not have a trial documented of the H-wave stimulation device. The guidelines recommend a 1 month home-based trial of H-wave stimulation. The rental is recommended for the 1 month trial period when it comes to home devices. The request submitted for review did not indicate whether this was a rental request or a purchase request. Given the information submitted for review, the request for a home H-wave device is non-certified.