

Case Number:	CM13-0035375		
Date Assigned:	12/13/2013	Date of Injury:	07/09/2013
Decision Date:	02/12/2014	UR Denial Date:	10/07/2013
Priority:	Standard	Application Received:	10/17/2013

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 Ohio and Texas. 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 employee is a 34-year-old male who reported an injury on 7/9/13. The mechanism of injury was noted as lifting a tool bag. His symptoms include back pain with radiation into his groin. Physical exam findings at his 9/5/13 office visit included normal range of motion of the cervical spine and the bilateral shoulders, limited range of motion of the lumbar spine noted as 50 degrees of flexion, 20 degrees of extension, and 20 degrees of right and left lateral bending, mild tenderness to palpation in the lumbosacral junction on the left side, tenderness in the left groin area over his testicle, and mild tenderness in the left paraspinal area. It was also noted that the employee had normal sensation and motor strength to the bilateral lower extremities. The provider noted a fair amount of central stenosis of the lumbar spine, both at L3-4 and L4-5, with lateral recess stenosis, degenerative disc disease, and question of left testicular pain from the back versus a hernia. A physical therapy note dated 9/16/13 stated that the employee had demonstrated a fair response to therapy and his motivation and compliance were rated as good. His range of motion was noted to be normal and full in bilateral rotation, 10% limited in lateral flexion, full and normal in forward flexion, and 10% limited in extension.

IMR ISSUES, DECISIONS AND RATIONALES

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

Additional physical therapy 2 sessions per week for 4 weeks (8 sessions): Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Physical Therapy Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99.

Decision rationale: The Chronic Pain Medical Treatment Guidelines recommend a physical therapy regimen of 9 to 10 visits over 8 weeks for myalgia and myositis, and 8 to 10 visits over 4 weeks for neuralgia, neuritis, and radiculitis. It was noted that the employee had previous physical therapy; however, the number of visits the employee completed was not documented in the submitted medical records. Additionally, there is a lack of documentation of functional gains and improvements made with previous visits in the records provided. Further, the employee's most recent physical examination findings were negative for significant functional deficits. For these reasons, the requested additional physical therapy 2 sessions per week for 4 weeks (8 sessions) is not medically necessary and appropriate.

Retrospective capsaicin/camphor/menthol/lidocaine/gabapentin (Caps/Camp/Men/Lid/Ga) Cream: 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): 111-113.

Decision rationale: The Chronic Pain Medical Treatment Guidelines state that topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. These medications are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. The Guidelines further indicate that any compounded product that contains at least one drug that is not recommended is not supported. The use of compounded agents requires knowledge of the specific analgesic effect of each agent and how it will be useful for the specified therapeutic goal required. In this case, a request was made for a topical compounded product that contains capsaicin, camphor, menthol, lidocaine, and gabapentin. The Guidelines state that capsaicin is recommended only as an option in patients who have not responded or are intolerant to other treatments. Lidocaine is recommended as a Lidoderm patch only for neuropathic pain and is not recommended for non-neuropathic pain. Gabapentin is not recommended for topical application, as there is no peer-reviewed literature to support its use. Given that gabapentin is not recommended for topical use, lidocaine is only recommended as a Lidoderm patch for neuropathic pain, and capsaicin is only recommended for patients who have not responded to or are intolerant of other treatments (which is not documented in the case of this employee), the request for this compounded topical medication is not supported. Therefore, the retrospective Caps/Camp/Men/Lid/Ga Cream is not medically necessary and appropriate.

Retrospective gabapentin/capsaicin solution: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Page(s): 47-48.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113.

Decision rationale: The Chronic Pain Medical Treatment Guidelines state that topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. These medications are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. The Guidelines further state that any compounded product that contains at least one drug that is not recommended is not supported. The use of compounded agents requires knowledge of the specific analgesic effect of each agent and how it will be useful for the specified therapeutic goal required. A request was made for gabapentin/capsaicin solution. The guidelines state that topical gabapentin is not recommended, as there is no peer-reviewed literature to support its use. Capsaicin is only recommended as an option in patients who have not responded to or are otherwise intolerant of other treatments. The documentation submitted for review does not demonstrate that the employee failed to respond to or was intolerant of other treatments. For these reasons, the requested retrospective gabapentin/capsaicin solution is not medically necessary and appropriate.