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| Case Number: | CM13-0038943 | | |
| Date Assigned: | 12/18/2013 | Date of Injury: | 05/26/2009 |
| Decision Date: | 05/21/2014 | UR Denial Date: | 09/18/2013 |
| Priority: | Standard | Application Received: | 10/01/2013 |

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 Texas and Ohio. 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 43-year-old female who reported an injury on 05/26/2009, secondary to a fall. The current diagnoses include lumbar radiculopathy, chronic mid and low back pain, left knee arthralgia, and neck pain. The injured worker was evaluated on 08/12/2013. Previous conservative treatment includes 24 sessions of physical therapy. Physical examination revealed an antalgic gait, tenderness to palpation, decreased cervical range of motion, decreased thoracic and lumbar range of motion, decreased sensation in the C5 through C8 dermatomes, decreased sensation in the L4 through S1 dermatomes, and decreased strength in bilateral lower extremities with positive straight leg raising on the left. Treatment recommendations at that time included prescriptions for Hydrocodone 5/325 mg and a compounded cream.

IMR ISSUES, DECISIONS AND RATIONALES

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

COMPOUND MEDICATION: CM4-CAPS 0.05%+CYCLO 4%: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints, Chronic Pain Treatment Guidelines.

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

Decision rationale: California MTUS Guidelines state topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. Any compounded product that contains at least 1 drug that is not recommended, is not recommended as a whole. Muscle relaxants are not recommended, as there is no evidence for the use of any muscle relaxant as a topical product. Therefore, the current request cannot be determined as medically appropriate. There is also no frequency or quantity listed in the current request. As such, the request is not medically necessary and appropriate.