

Case Number:	CM14-0004373		
Date Assigned:	02/05/2014	Date of Injury:	09/08/2013
Decision Date:	06/30/2014	UR Denial Date:	01/08/2014
Priority:	Standard	Application Received:	01/13/2014

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 31 year old female who reported an injury on 09/08/2013 due to a motor vehicle accident. The injured worker has a history of persistent pain of the low back that is aggravated with usual activities, left wrist and hand pain, and right shoulder pain. The examination on 12/03/2013 of the right shoulder reveal tenderness at the subacromial space and upper trapezial muscles. Axial loading compression test and Spurling's maneuver, shoulder impingement and Hawkins' signs were positive. The left hand and wrist had some pain in the first dorsal compartment and a positive Finkelstein's test with some paresthesias and numbness. The lumbar spine has tenderness from the mid to distal lumbar segments, pain with terminal motion, and seated nerve root test was positive. The injured worker has a history of lumbar discopathy, rule out internal derangement right shoulder, and left De Quervain's/left wrist sprain and strain. The medications dispensed on 09/08/2013 were Acetaminophen 500mg, Etodolac ER 600mg, Tramadol/Acet HCL 37.5/325mg and Cyclobenzaprine 5mg. The treatment plan is for Cooleeze gel and Gabapentin 10% in Capsaicin spray. Request for authorization form and rationale for the request were not provided within the documentation submitted for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

TOPICALLY APPLIED MEDICATION: COOLEEZE GEL: Upheld

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

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

Decision rationale: The request for Cooleeze gel is not medically necessary. The injured worker has a history of persistent pain of the low back that is aggravated with usual activities, left wrist and hand pain, and right shoulder pain. California Medical Treatment Utilization Schedule (MTUS) Guidelines state that largely experimental in use with few randomized controlled trials to determine efficacy or safety. There is a lack of rationale to support the proposed gel. There is no indication that the injured worker cannot use cold/ice packs. In addition, the request does not include the frequency and/or quantity of the proposed medication. As such, the request for the above is not medically necessary.

TOPICALLY APPLIED MEDICATION: GABAPENTIN 10% IN CAPSAICIN SPRAY:
Upheld

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

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

Decision rationale: The request for Gabapentin 10% in Capsaicin spray is not medically necessary. The injured worker has a history of persistent pain of the low back that is aggravated with usual activities, left wrist and hand pain, and right shoulder pain. California Medical Treatment Utilization Schedule (MTUS) guidelines do not recommend the use of Gabapentin because there is no peer-reviewed literature to support use. Also compound agents are not recommended. The request is for Gabapentin in Capsaicin. In addition, the request does not include the frequency and/or quantity of the proposed medication. As such, the request for the above is not medically necessary.