

Case Number:	CM14-0101119		
Date Assigned:	07/30/2014	Date of Injury:	07/09/2013
Decision Date:	09/16/2014	UR Denial Date:	05/30/2014
Priority:	Standard	Application Received:	06/30/2014

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 & Rehabilitation and is licensed to practice in California. 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 male who reported injury on 07/09/2013. The mechanism of injury was the injured worker was thrown. The surgical history was not provided. The diagnoses included cervical, thoracic and lumbar spine and bilateral shoulder pain, sprain and strain. The injured worker was noted to have undergone an MRI of the lumbar spine. Prior treatments were noted to included physical therapy and medications, as well as chiropractic care. The documentation of 05/14/2014 revealed the injured worker had no change since the examination of 03/12/2014. The injured worker was noted to have tenderness in the cervical and cervicothoracic region, as well as in the bilateral shoulders. The injured worker had tenderness in the right radial and dorsal wrist. The injured worker had a positive Hawkins' and Neer's test in the bilateral shoulders. The injured worker had spasms in the cervicothoracic spine. The injured worker's sensory and motor testing were noted to be within normal limits. There was no atrophy noted. The treatment plan was noted to included physical therapy 2 times a week for 3 weeks to the cervical spine and bilateral shoulders, a consultation for pain management and lumbar spine orthosis and medications including Motrin twice a day, naproxen cream as needed 240 g and Polar Freeze as needed 240 g with 1 refill. There was a descriptive DWC Form Request for Authorization for the requested service.

IMR ISSUES, DECISIONS AND RATIONALES

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

Polar freeze 240gm with 1 refill: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Salicylate Topicals, , Topical Analgesic Page(s): 105 111.

Decision rationale: The California MTUS guidelines indicate that topical analgesics are largely experimental in use with few randomized control trials to determine efficacy or safety... are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. The guidelines recommend treatment with topical salicylates. The clinical documentation submitted for review failed provide the injured worker had neuropathic pain. There was a lack of documentation indicating the injured worker had trialed and failed antidepressants and anticonvulsants. The duration of use could not be established through the supplied documentation. The request, as submitted, failed to indicate the frequency for the requested medication. There was a lack of documentation indicating a necessity for 1 refill without re-evaluation. Given the above, the request for Polar Freeze 240 g with 1 refill is not medically necessary.