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| Case Number: | CM14-0116861 | | |
| Date Assigned: | 08/04/2014 | Date of Injury: | 09/03/2009 |
| Decision Date: | 09/10/2014 | UR Denial Date: | 07/02/2014 |
| Priority: | Standard | Application Received: | 07/24/2014 |

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 underlying date of injury in this case is 09/03/2009. The mechanism of injury is that the patient was injured when climbing down from a step stool, and she lost her balance and fell backward. As on 06/16/2014, the primary treating physician noted the patient has ongoing low back pain with numbness and tingling into the lower extremities. The patient was noted to be status post lumbar fusion with removal of hardware and a history of subsequent wound dehiscence. The treatment plan was for more stabilization and a back brace. The treating physician recommended physical therapy for thoracic and lumbar spine and also noted the patient needed to continue with multiple topical creams.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical Therapy to thoracic and lumbar spine QTY 8: Upheld

Claims Administrator guideline: Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 2 -3; 15-16.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Section on physical medicine, page(s) 98-99 Page(s): 98-99.

Decision rationale: The Medical Treatment Utilization Schedule Chronic Pain Medical Treatment Guidelines section on physical medicine recommends transition to an independent

active home rehabilitation program. The medical records do not provide a rationale as to why this patient requires additional supervised therapy rather than further independent home rehabilitation. The records do discuss the need for a back brace and dehiscence of the patient's spinal wound. Overall the records are not clear, however, regarding the specific goals of current physical therapy. Therefore, given the lack of specific current treatment goals, this request is not supported by the treatment guidelines. This request is not medically necessary.

Flurbiprofen 20%: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Section on topical analgesics, page(s) 111-112 Page(s): 111-112.

Decision rationale: The Medical Treatment Utilization Schedule Chronic Pain Medical Treatment Guidelines section on topical analgesics, page 111-112, states that topical antiinflammatory medications are recommended only for short-term use but not chronic use. This same guideline discusses an alternative topical antiinflammatory medication of Voltaren Gel and notes that this has not been evaluated for treatment of the spine. Overall the medical records do not document an indication or other rationale to support a probable benefit from flurbiprofen. This request is not medically necessary.

Ketoprofen 20%/Ketamine 10% cream 120gm: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 56, 112-113.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Section on topical analgesics page(s) 111 Page(s): 111.

Decision rationale: The Medical Treatment Utilization Schedule Chronic Pain Medical Treatment Guidelines section on topical analgesics, page 111, discusses topical ketoprofen and recommends that this not be utilized for topical use due to an FDA advisory regarding photocontact dermatitis. This same guideline discusses ketamine and states that this is only recommended in refractory cases in which all other treatment options have been exhausted. Neither of these medications is currently supported by the treatment guidelines. Overall I recommend this request be noncertified.

Gabapentin 10%/Cyclobenzaprine 10%/Capsaicin 0.0375% cream 120gm: Upheld

Claims Administrator guideline: Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 28-29, 112-113.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Section on topical analgesics, page(s) 111 Page(s): 111.

Decision rationale: The Medical Treatment Utilization Schedule Chronic Pain Medical Treatment Guidelines section on topical analgesics, page 111, states that any compounded product that contains at least 1 drug that is not recommended is not recommended. This same guideline specifically does not recommend gabapentin or cyclobenzaprine for topical use. The records do not provide an alternate rationale for an exception to this guideline. This request is not medically necessary.