

Case Number:	CM14-0125008		
Date Assigned:	09/18/2014	Date of Injury:	01/27/2006
Decision Date:	10/16/2014	UR Denial Date:	07/28/2014
Priority:	Standard	Application Received:	08/07/2014

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, has a subspecialty in Pain Management, 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:

This is a female patient with the date of injury of January 27, 2006. A Utilization Review was performed on July 28, 2014 and recommended as not medically necessary of (Retrospective) Topical Cream (type, strength, and quantity unspecified). An Evaluation dated July 2, 2014 identifies History of Present Illness of chronic left upper extremity pain. Physical exam identifies tender to palpation in the bilateral cervical paraspinal. She does have some mildly decreased range of motion towards the left side. Left shoulder range of motion is decreased. There is mild swelling around the left wrist and left wrist extension is slightly decreased compared to the right. Impression identifies chronic left upper extremity pain, left upper extremity CRPS, chronic neck pain, history of depression, and neuropathic pain. Treatment Plan identifies she is dispensed topical cream from the clinic to help with her left upper extremity pain.

IMR ISSUES, DECISIONS AND RATIONALES

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

Topical Cream (type, strength, and quantity unspecified): 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 Page(s): 111-113.

Decision rationale: Regarding the request for (Retrospective) Topical Cream (type, strength, and quantity unspecified), CA MTUS states that topical compound medications require guideline support for all components of the compound in order for the compound to be approved. Within the information made available for review, there is no clarification as to what the components of the topical cream are. In the absence of such documentation, the currently requested (Retrospective) Topical Cream (type, strength, and quantity unspecified) is not medically necessary.