MAXIMUS Federal Services

Case Number:	CM14-0130949		
Date Assigned:	09/03/2014	Date of Injury:	03/03/2003
Decision Date:	10/03/2014	UR Denial Date:	08/01/2014
Priority:	Standard	Application Received:	08/15/2014

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 Emergency Medicine and is licensed to practice in Texas. 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 63 year old female who reported an injury on 03/03/2003 with an unknown mechanism of injury. The injured worker was diagnosed with cervicothoracic, bilateral shoulder, and bilateral upper extremity conditions. The injured worker was treated with topical medication, acupuncture, TENS unit, aquatherapy, and surgery. The injured worker had official MRI of the cervical spine on 09/04/2014. The injured worker had right carpel tunnel release on 09/14/2004. On the clinical note dated 01/07/2014 the injured worker complained of a locked feeling in right arm with severe pain, poor sleep due to pain level, and unable to tolerate oral medications. The injured worker had 4/5 strength in upper extremities, functional range of motion in upper extremities, limited range of motion to neck and upper extremities, tight, taught bands of muscle in the dorsal forearms, neck and shoulders, and tender to palpitation in the cervical myofascial greater on the left than right. The injured worker was prescribed biofreeze. The treatment plan was for medication staton cream 3B. The rationale for the request was the injured worker was unable to tolerate oral medications. The request for authorization was not submitted for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Medication Staton Cream 3B: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints. Decision based on Non-MTUS Citation ODG (Official Disability Guidelines)Neck & Upper Back Chapter

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics, Page(s): 111-112.

Decision rationale: The request for medication staton cream 3B is not medically necessary. The injured worker is diagnosed with cervicothoracic, bilateral shoulder, and bilateral upper extremity conditions. The injured worker complains of a locked feeling in right arm with severe pain, poor sleep due to pain level, and unable to tolerate oral medications. The California MTUS guidelines recommend topical analgesics primarily for neuropathic pain when trials of antidepressants and anticonvulsants have failed. The request does not indicate the ingredients of the topical cream and the ingredients were not indicated within the medical records and could not be discerned after extensive research of the medication. The injured worker's medical records lack documentation of the efficacy of the medication. Additionally, the request does not indicate the dosage, frequency, quantity, and the application site. As such, the request for medication staton cream 3B is not medically necessary.