

Case Number:	CM14-0094293		
Date Assigned:	07/25/2014	Date of Injury:	01/23/2014
Decision Date:	09/12/2014	UR Denial Date:	04/02/2014
Priority:	Standard	Application Received:	04/30/2014

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 and Rehabilitation and is licensed to practice in Nevada. 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 34-year-old male who was reportedly injured on 1/23/2014. The mechanism of injury was noted as an industrial injury. The most recent progress note dated 4/2/2014, indicated that there were ongoing complaints of upper back, bilateral upper extremity and low back pains. The physical examination demonstrated cervical spine, positive tenderness to palpation with spasms of the right suboccipital. Range of motion is limited secondary to pain. Sensory and motor exam are within normal limits. Thoracolumbar spine revealed tenderness to palpation with spasms to lumbar paraspinal. Range of motion is secondary to pain. Motor and sensory exam is within normal limits. Upper extremity limited range of motion secondary to pain of wrist/hand. Range of motion of the digits was full with the exception of the second digit. Metacarpophalangeal flexes to 80, proximal interphalangeal joint to 40 and distal interphalangeal joint flexes less than 5. No recent diagnostic studies are available for review. Previous treatment included medication and conservative treatment. A request was made for Capsaicin Transdermal Cream, Flurbiprofen Transdermal Cream and was not certified in the pre-authorization process on 4/2/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retro Capsaicin Transdermal Cream (DOS: 3-20-2014) 240gm: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG and other EBM.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 112, 113 of 127.

Decision rationale: California Medical Treatment Utilization Schedule Guidelines support the use of Capsaicin for individuals who are intolerant to other treatments for the management of osteoarthritis at doses of 0.025%, but it is considered experimental in very high doses. Based on the clinical documentation provided, the claimant fails to meet criteria as outlined by the guidelines. As such, the request for retro Capsaicin Transdermal Cream is not medically necessary.

Retro Flurbiprofen Transdermal Cream (DOS: 3-20-2014) 240gm: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG and other EBM.

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

Decision rationale: California Medical Treatment Utilization Schedule Guidelines support topical non-steroidal anti-inflammatory drugs for the short-term treatment of osteoarthritis and tendinitis for individuals unable to tolerate oral non-steroidal anti-inflammatories. The guidelines support 4-12 weeks of topical treatment for joints that are amendable to topical treatments; however, there is little evidence to support treatment of osteoarthritis of the spine, hips or shoulders. When noting the claimant's diagnosis, date of injury and clinical presentation, the request for retro Flurbiprofen Transdermal Cream is not medically necessary.