

Case Number:	CM14-0154563		
Date Assigned:	09/24/2014	Date of Injury:	04/07/2004
Decision Date:	01/27/2015	UR Denial Date:	08/27/2014
Priority:	Standard	Application Received:	09/22/2014

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 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 64 year-old male, who sustained an injury on April 7, 2004. The mechanism of injury occurred from cumulative trauma. Diagnostics have included: February 28, 2013 Lumbar MRI reported as showing evidence of L4-5 fusion. Treatments have included: medications, lumbar spinal fusion. The current diagnoses are: low back pain, lumbar disc displacement, lumbar radiculopathy, lumbar post-laminectomy syndrome. The stated purpose of the request for COOLEEZE (MENTH/CAMP/ CAP/ HYALOR ACID) 3.5% 0.5%/ 006%/ 0.2% QTY 120#1 WITH 1 REFILL was not noted. The request for COOLEEZE (MENTH/CAMP/ CAP/ HYALOR ACID) 3.5% 0.5%/ 006%/ 0.2% QTY 120#1 WITH 1 REFILL was denied on August 27, 2014, citing a lack of documentation of guideline-support. The stated purpose of the request for FLUR/ CYC;P/CAPS/LID (10%/2%/0.0125%/1\$) QTY 120 #1 WITH 1 REFILL was not noted. The request for FLUR/ CYC;P/CAPS/LID (10%/2%/0.0125%/1\$) QTY 120 #1 WITH 1 REFILL was denied on August 27, 2014, citing a lack of documentation of guideline support. Per the report dated July 24, 2014, the treating physician noted complaints of low back pain with radiation to both legs. Exam showed lumbar paraspinal tenderness and spasm, positive bilateral straight leg raising tests.

IMR ISSUES, DECISIONS AND RATIONALES

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

Cooleeze (Menth/Camp/ Cap/ Hyalor Acid) 3.5% 0.5%/ 006%/ 0.2% QTY 120#1 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 Topical Analgesics Page(s): 111-113.

Decision rationale: The requested COOLEEZE (MENTH/CAMP/ CAP/ HYALOR ACID) 3.5% 0.5%/ 0.06%/ 0.2% QTY 120#1 WITH 1 REFILL, is not medically necessary. California Medical Treatment Utilization Schedule (MTUS), 2009, Chronic pain, page 111-113, Topical Analgesics, do not recommend topical analgesic creams as they are considered "highly experimental without proven efficacy and only recommended for the treatment of neuropathic pain after failed first-line therapy of antidepressants and anticonvulsants". The injured worker has low back pain with radiation to both legs. The treating physician has documented lumbar paraspinal tenderness and spasm, positive bilateral straight leg raising tests. The treating physician has not documented trials of anti-depressants or anti-convulsants. The treating physician has not documented intolerance to similar medications taken on an oral basis. The criteria noted above not having been met, COOLEEZE (MENTH/CAMP/ CAP/ HYALOR ACID) 3.5% 0.5%/ 0.06%/ 0.2% QTY 120#1 WITH 1 REFILL is not medically necessary.

Flur/ Cyc;P/Caps/Lid (10%/2%/0.0125%/1\$) Qty 120 #1 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 Topical Analgesics Page(s): 111-113.

Decision rationale: The requested FLUR/ CYC;P/CAPS/LID (10%/2%/0.0125%/1\$) QTY 120 #1 WITH 1 REFILL, is not medically necessary. California Medical Treatment Utilization Schedule (MTUS), 2009, Chronic pain, page 111-113, Topical Analgesics, do not recommend topical analgesic creams as they are considered "highly experimental without proven efficacy and only recommended for the treatment of neuropathic pain after failed first-line therapy of antidepressants and anticonvulsants". The injured worker has low back pain with radiation to both legs. The treating physician has documented lumbar paraspinal tenderness and spasm, positive bilateral straight leg raising tests. The treating physician has not documented trials of anti-depressants or anti-convulsants. The treating physician has not documented intolerance to similar medications taken on an oral basis. The criteria noted above not having been met, FLUR/ CYC;P/CAPS/LID (10%/2%/0.0125%/1\$) QTY 120 #1 WITH 1 REFILL is not medically necessary.