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| Case Number: | CM15-0088116 | | |
| Date Assigned: | 05/12/2015 | Date of Injury: | 11/22/2013 |
| Decision Date: | 06/15/2015 | UR Denial Date: | 04/08/2015 |
| Priority: | Standard | Application Received: | 05/07/2015 |

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
 State(s) of Licensure: New York, West Virginia, Pennsylvania
 Certification(s)/Specialty: Emergency Medicine

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 60 year old female, who sustained an industrial injury on 11/22/2013. She reported neck, right shoulder, right knee, and low back pain. The injured worker was diagnosed as having internal derangement of the knee, lumbar intervertebral disc disorder with myelopathy, sciatica, and shoulder rotator cuff syndrome. Treatment to date has included medications, and modified duty. The request is for FCL topical compound cream, and interferential stimulator home unit. On 4/3/2015, she complained of no pain of right anterior shoulder, right cervical dorsal, right posterior shoulder, left lumbar, left sacroiliac, lumbar, right lumbar, right sacroiliac, and sacral pain. The record indicated she rated her pain as 0/10. Physical findings are noted to be tenderness at right anterior shoulder, cervical, left cervical dorsal, right cervical dorsal, upper thoracic, left mid thoracic, right mid thoracic, left sacroiliac, lumbar, right sacroiliac, sacral, left buttock, right buttock, right posterior leg, left posterior leg, and right anterior knee. The treatment plan included: compound cream and interferential stimulation.

IMR ISSUES, DECISIONS AND RATIONALES

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

FCL topical compound cream 180gms: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical analgesics.

Decision rationale: Guidelines state that topical analgesics are largely experimental and may be used for neuropathic pain when trials of antidepressants and anticonvulsants have failed. In this case, the patient has no pain complaints and there is no indication that the patient failed trials of first line medications. The request for FCL compound cream #180 gms is not medically necessary.

Interferential stimulator home unit rental for 60 days: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential current stimulation Page(s): 118-120.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation Page(s): 114-121.

Decision rationale: Guidelines state that interferential current stimulation is not recommended as an isolated intervention. In this case, there is no documentation of a prior trial of an IF unit resulting in functional improvement and it is not clear how IF is predicted to positively impact the claimants function when efficacy is not yet established. It also is not clear if the patient is participating in any adjunct exercises. The request is not medically necessary.