

Case Number:	CM14-0142440		
Date Assigned:	09/10/2014	Date of Injury:	02/20/2004
Decision Date:	10/24/2014	UR Denial Date:	08/28/2014
Priority:	Standard	Application Received:	09/03/2014

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 Family 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 49 year old male injured on February 20, 2004 when involved in a motor vehicle collision resulting in multiple rib fractures, torn meniscus, pneumothorax, and low back pain. The initial treatments rendered were not discussed in the clinical documentation provided. The injured worker was subsequently diagnosed with discogenic low back pain with bilateral lumbar radiculopathy. The injured worker underwent meniscus repair in 2005. Previous conservative management including massage, six months physical therapy, and medication management including Vicodin and Soma. Clinical note dated July 29, 2014 indicated the injured worker presented complaining of progressively worsening low back pain over previous three years with numbness in bilateral lower extremities and feet. The injured worker reported constant low back pain with baseline 3/10 with increase to 6/10 with activity including prolonged walking and standing. The injured worker reported occasional numbness in the distal aspect of bilateral legs and feet in addition to weakness in bilateral legs, right greater than left. Treatment plan included MRI of the lumbar spine, lumbar spine epidural steroid injection, and prescription for transdermal pain cream. The initial request was non-certified on August 28, 2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Transdermal Pain Cream: 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 Page(s): 111.

Decision rationale: As noted on page 111 of the Chronic Pain Medical Treatment Guidelines, the safety and efficacy of compounded medications has not been established through rigorous clinical trials. CAMTUS, Food and Drug Administration, and Official Disability Guidelines require that all components of a compounded topical medication be approved for transdermal use. The individual components of the transdermal cream were not provided to establish United States Federal Drug Administration approval status. In addition, there is no evidence within the medical records submitted that substantiates the necessity of a transdermal versus oral route of administration. Therefore, Transdermal Pain Cream is not medically necessary as it does not meet established and accepted medical guidelines.

Physical Therapy x 18 visits, Lumbar Spine: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Lumbar & Thoracic (Updated 08/22/2014), Physical Therapy Guidelines

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98.

Decision rationale: As noted on page 98 of the Chronic Pain Medical Treatment Guidelines, current guidelines recommend 10 visits over 8 weeks for the treatment of lumbar strain/sprain and allow for fading of treatment frequency (from up to 3 or more visits per week to 1 or less), plus active self-directed home physical therapy. Additionally, guidelines indicate assessment of functional improvement should occur after a "six visit clinical trial" prior to additional sessions. As such, the request for 18 physical therapy sessions exceeds the recommended trial of 6 sessions. The medical necessity of the Physical Therapy x 18 visits, Lumbar Spine cannot be established at this time.