

Case Number:	CM14-0162622		
Date Assigned:	10/07/2014	Date of Injury:	11/28/1990
Decision Date:	11/07/2014	UR Denial Date:	09/04/2014
Priority:	Standard	Application Received:	10/03/2014

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 Anesthesiology, has a subspecialty in Pain Management 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:

According to the records made available for review, this is a 64-year-old female with an 11/28/90 date of injury. At the time (8/19/14) of request for authorization for [REDACTED] pain cream with 4 refills, there is documentation of subjective (low back pain radiating into the bilateral hips) and objective (tenderness to palpitation over the left lumbar facet, axial loading of the lumbar spine worsens the pain, decreased range of motion of the lumbar spine positive straight leg raise test, numbness at L4/5 level, and decreased patellar and ankle reflexes bilaterally) findings, current diagnoses (severe lumbar disc disease, acute recent flare in back pain, and status post decompression and anterior/posterior fusion at L4-L5 and L5-S1), and treatment to date (physical therapy, massage therapy, chiropractic treatment, and medications (including NSAIDS)). There is no documentation that trials of antidepressants and anticonvulsants have failed.

IMR ISSUES, DECISIONS AND RATIONALES

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

[REDACTED] pain cream with 4 refills: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM, Chronic Pain Treatment Guidelines.

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

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines identifies that topical analgesics are recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Within the medical information available for review, there is documentation of diagnoses of severe lumbar disc disease, acute recent flare in back pain, and status post decompression and anterior/posterior fusion at L4-L5 and L5-S1. In addition, there is documentation of neuropathic pain. However, there is no documentation that trials of antidepressants and anticonvulsants have failed. Therefore, based on guidelines and a review of the evidence, the request for [REDACTED] pain cream with 4 refills is not medically necessary.