

Case Number:	CM14-0194171		
Date Assigned:	12/01/2014	Date of Injury:	03/29/2014
Decision Date:	01/14/2015	UR Denial Date:	10/31/2014
Priority:	Standard	Application Received:	11/19/2014

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 Orthopedic Surgery and is licensed to practice in New Jersey. 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 56-year-old male who reported an injury on 03/29/2014. The mechanism of injury was a fall. The diagnosis included lumbar stenosis. The past treatments included physical therapy and surgical intervention. There was no official diagnostic imaging studies submitted for review. The surgical history was noted to include lumbar surgery. The subjective complaints on 10/01/2014 included continuous lumbar pain that radiates to the right buttock. The injured worker rates the pain 4/10 to 5/10. The physical examination revealed tenderness to palpation of the paraspinal musculature bilaterally. The straight leg raise test was positive on the right. The muscle strength was rated 4/5 on the right lower extremity and 5/5 on the left lower extremity. The injured worker's medications were noted to include ibuprofen 800 mg. The treatment plan was to refill Ibuprofen, prescribe Kera-Tek analgesic gel, and request physical therapy. A request was received for Kera-Tek analgesic gel, physical therapy to neck for 12 visits at 2 times a week for 6 weeks, and a urine toxicology screen. The Request for Authorization form was not submitted for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Kera-Tek Analgesic Gel: 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): 111-112.

Decision rationale: The request for Kera-Tek analgesic gel is not medically necessary. The California MTUS Chronic Pain Guidelines state that topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. The guidelines also state that any compounded product that contains at least 1 drug (or drug class) that is not recommended is not recommended. Topical compounds are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. There was a lack of documentation that the injured worker has tried and failed first line therapy (i.e. antidepressants and anticonvulsants). Given the above, the request is not supported by the evidence based guidelines. As such, the request is not medically necessary.

Physical Therapy to the Neck for 12 Visits at 2 times a week for 6 weeks: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Post Surgical Physical Medicine.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck and Upper Back, Physical therapy (PT)

Decision rationale: The request for physical therapy to the neck for 12 visits at 2 times a week for 6 weeks is not medically necessary. The Official Disability Guidelines state that for cervicalgia up to 9 visits of physical therapy may be supported. The guidelines also state that continued visits are contingent upon objective functional improvement. It is documented in the clinical notes that the injured worker has completed an unspecified amount of physical therapy sessions. However, there was a lack of objective functional improvement from the previous sessions completed. In the absence of objective functional improvement from the previous physical therapy sessions, the request is not supported by the evidence based guidelines. As such, the request is not medically necessary.

Drug Screen, other than Chromatographic Quantity: 1 (Urine Toxicology Screen): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Drug Screening.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Drug testing Page(s): 77.

Decision rationale: The request for drug screen, other than chromatographic quantity: 1 (urine toxicology screen) is not medically necessary. The California MTUS Chronic Pain Guidelines state that steps to take before a therapeutic trial of opioids are to consider the use of a urine drug screen to assess for the use or presence of illegal drugs. There was a lack of documentation in the clinical notes that the injured worker is on opioids or is being prescribed a trial of opioid

medications to warrant a urine toxicology screen. Given the above information, the request is not supported by the evidence based guidelines. As such, the request is not medically necessary.