

Case Number:	CM14-0217683		
Date Assigned:	01/07/2015	Date of Injury:	08/02/1996
Decision Date:	03/20/2015	UR Denial Date:	12/01/2014
Priority:	Standard	Application Received:	12/29/2014

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. 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: Arizona, California
 Certification(s)/Specialty: Family Practice

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 67 year old female, who sustained an industrial injury on August 2, 1996. The diagnoses have included sciatica improved status post epidural steroid injection, multilevel lumbar degenerative disc disease, status post right total knee arthroplasty, history of severe motor and sensory peripheral neuropathy and status post spinal cord stimulator implant. Treatment to date has included caudal epidural steroid injection on January 23, 2014, implanted spinal cord stimulator on July 29, 2010, oral pain medication, transdermal patches and Amrix, total knee arthroplasty on February 18, 2005, multilevel lumbar, and laminectomy in 2001 followed by L2-L5 lumbar fusion in August 2003. Currently, the injured worker complains of back pain radiating into the right leg with weakness and having difficulty ambulating. In a progress note dated November 17, 2014, the treating provider reports examination of the lumbar spine has moderate lumbar paraspinous tenderness right greater than left, restricted range of motion, positive straight leg raise on the right and hyperthesia in the right L5 dermatome. On December 1, 2014 Utilization Review non-certified a KGL cream 240gm, noting, Medical Treatment Utilization Schedule Guidelines was cited.

IMR ISSUES, DECISIONS AND RATIONALES

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

KGL cream #240g: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines topical analgesics Page(s): 111-112.

Decision rationale: According to the MTUS guidelines, topical analgesics are recommended as an option as indicated below. They are largely experimental in use with few randomized controlled trials to determine efficacy or safety. Primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Topical Gabapentin is not recommended due to lack of evidence for its use. The compound in question contains topical Gabapentin. The claimant had also been on oral analgesics. The KGL cream is therefore not medically necessary.