

Case Number:	CM15-0110650		
Date Assigned:	06/17/2015	Date of Injury:	11/23/2013
Decision Date:	07/15/2015	UR Denial Date:	05/27/2015
Priority:	Standard	Application Received:	06/08/2015

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 Jersey, Alabama, California
 Certification(s)/Specialty: Neurology, Neuromuscular 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 47 year old male who sustained a work related injury November 13, 2013. He describes cumulative trauma working as a machine operator to his head, neck, lower back, right shoulder, upper arm, and both hands. According to a secondary treating physician's progress report, dated May 20, 2015, the injured worker presented complaining of low back pain radiating to the right leg. Objective findings included a positive Faber's on the right and positive thigh thrust. Diagnoses are right sacroilitis; degenerative disc disease L5-S1 with facet arthropathy and foraminal stenosis. A diagnosis documented May 13, 2015, by the primary treating physician also included a C5-C6 3mm C6-C7 2mm disc herniation. Treatment plan included request to inject right sacroiliac joint. At issue, is the request for authorization for topical cream.

IMR ISSUES, DECISIONS AND RATIONALES

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

Topical 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: According to MTUS, in Chronic Pain Medical Treatment guidelines section Topical Analgesics (page 111), topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. Many agents are combined to other pain medications for pain control. There is limited research to support the use of many of these agents. Furthermore, according to MTUS guidelines, any compounded product that contains at least one drug or drug class that is not recommended is not recommended. There is no documentation of failure of first line therapy for pain. Therefore, the request for topical cream is not medically necessary.