

Case Number:	CM15-0172204		
Date Assigned:	09/14/2015	Date of Injury:	02/07/2012
Decision Date:	10/21/2015	UR Denial Date:	08/19/2015
Priority:	Standard	Application Received:	09/01/2015

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: California, Hawaii
 Certification(s)/Specialty: Physical Medicine & Rehabilitation

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

This injured worker is a 54 year old female who sustained an industrial injury on 02-07-2012. The injured worker was diagnosed as having lumbar hyperextension-hyperflexion injury, mild L5-S1 herniation with minimal left L5 radiculopathy, left hip bursitis-trochanteric, left piriformis syndrome, left hip psoas strain, left hip early degenerative arthrosis and spinal discopathy L4-L5 and L5-S1. On medical records dated 07-15-2015 and 06-03-2015, the subjective findings noted ongoing low back pain and lower extremity pain. Objective findings were noted as having an antalgic gait. Lumbar spine revealed tenderness in the paraspinous musculature of the lumbar region on the left. Midline tenderness, muscle spasm and a decreased range of motion was noted. Left sacroiliac tenderness on compression was noted as well as sciatic nerve compression on the left. Left hip revealed swelling and tenderness at the trochanteric region, with a decreased range of motion as well. Intramedial stress of the pelvis produces pain, and Trendelenburg test was positive on the left. The injured worker was noted as temporarily totally disabled. Treatments to date include medication and epidural injections. The Utilization Review (UR) was dated 08-19-2015 pain, tenderness, discomfort, limited motion and spasms in the hip area, left leg pain and low back pain. A Request for Authorization was dated 07-15-2015. The UR submitted for this medical review indicated that the request for compounded medication: Flurbiprofen 20% Baclofen 10% Dexamethasone 2% Menthol 2% Camphor 2% Capsaicin 0.0375% cream, 180gm and a Pro-Stim 5.0 purchase were non-certified.

IMR ISSUES, DECISIONS AND RATIONALES

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

Compounded medication: Flurbiprofen 20%/Baclofen 10%/Dexamethasone 2%/Menthol 2%/Camphor 2%/Capsaicin 0.0375% cream, 180gm: Upheld

Claims Administrator guideline: Decision based on MTUS General Approaches 2004, Section(s): Initial Approaches to Treatment, and Chronic Pain Medical Treatment 2009. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Topical Analgesics.

Decision rationale: The patient presents with pain affecting the low back and left hip. The current request is for Compounded medication: Flurbiprofen 20%/Baclofen 10%/Dexamethasone 2%/Menthol 2%/Camphor 2%/Capsaicin. The treating physician report dated 7/15/15 (13B) notes that the requested topical compound analgesic was prescribed for neuropathic pain. The MTUS guidelines have the following regarding topical analgesics: "Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended." The guidelines go on to state, "Baclofen: Not recommended." In this case, Baclofen is not recommended as a topical product by the MTUS guidelines. Furthermore, since Baclofen is not recommended, the requested topical compound is not recommended. The current request is not medically necessary.

Pro-Stim 5.0 purchase: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Transcutaneous electrotherapy.

Decision rationale: The patient presents with pain affecting the low back and left hip. The current request is for Pro-Stim 5.0 purchase. The treating physician report dated 7/15/15 (13B) states, "It is important that the patient be given the above device (Pro-Stim 5.0) to help facilitate rapid recovery for their industrial injury." The Pro-Stim 5.0 is a dual unit with both TENS and NMES. The MTUS guidelines do support a 30 day trial of a TENS unit for home usage for patients with neuropathy. The treating physician does not document that the patient has had a trial of a TENS unit or a neuro muscular electrical stimulation (NMES) unit. The MTUS does not support NMES usage for the treatment of chronic pain. In this case, the current request is for a dual unit, of which EMS or electrical muscle stimulator, also known as neuromuscular electrical stimulation NMES is specifically not recommended for chronic pain per MTUS. The current request is not medically necessary.