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| Case Number: | CM15-0029532 | | |
| Date Assigned: | 02/23/2015 | Date of Injury: | 05/22/2012 |
| Decision Date: | 04/01/2015 | UR Denial Date: | 02/12/2015 |
| Priority: | Standard | Application Received: | 02/18/2015 |

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

Certification(s)/Specialty: Emergency 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 40 year old female, who sustained an industrial injury on May 22, 2012. She has reported marked low back pain and spasm and persistent neck pain with radiation to the shoulder and upper extremities associated with tingling and numbness of the hands. The diagnoses have included clinical evidence of a disc herniation at the lumbar 5-sacral 1 levels and lumbago. Treatment to date has included radiographic imaging, diagnostic studies, trigger point injections, conservative therapies, pain medications and work restrictions. Currently, the IW complains of marked low back pain and spasm and persistent neck pain with radiation to the shoulder and upper extremities associated with tingling and numbness of the hands. The injured worker reported an industrial injury in 2012, resulting in the above described pain. She was treated with conservative therapies without a complete resolution of the pain. It was noted that a previous unrelated neck injury was resolved with trigger point injections. Evaluation on January 15, 2015, revealed continued pain. A magnetic resonance image of the cervical spine, topical pain medications and a urinary drug screen was requested and medications were renewed. On February 12, 2015, Utilization Review non-certified a request for Kera Tek gel #113, Flurb/cyclo/menth cream 20%, 10/4% 180gm, noting the MTUS, ACOEM Guidelines, (or ODG) was cited. On February 18, 2015, the injured worker submitted an application for IMR for review of requested Kera Tek gel #113, Flurb/cyclo/menth cream 20%, 10/4% 180gm.

IMR ISSUES, DECISIONS AND RATIONALES

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

Kera Tek Gel #113: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines page 111-113, Topical Analgesics Page(s): 111-113.

Decision rationale: The requested Kera Tek Gel #113, is not medically necessary. California Medical Treatment Utilization Schedule (MTUS), 2009, Chronic pain, page 111-113, Topical Analgesics, do not recommend topical analgesic creams as they are considered "highly experimental without proven efficacy and only recommended for the treatment of neuropathic pain after failed first-line therapy of antidepressants and anticonvulsants." The injured worker has marked low back pain and spasm and persistent neck pain with radiation to the shoulder and upper extremities associated with tingling and numbness of the hands. The treating physician has not documented trials of anti-depressants or anti-convulsants. The treating physician has not documented intolerance to similar medications taken on an oral basis. The criteria noted above not having been met, Kera Tek Gel #113 is not medically necessary.

Flurb/Cyclo/Menth Cream 20%/10/4% 180gm: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines page 111-113, Topical Analgesics Page(s): 111-113.

Decision rationale: The requested Flurb/Cyclo/Menth Cream 20%/10/4% 180gm, is not medically necessary. California Medical Treatment Utilization Schedule (MTUS), 2009, Chronic pain, page 111-113, Topical Analgesics, do not recommend topical analgesic creams as they are considered "highly experimental without proven efficacy and only recommended for the treatment of neuropathic pain after failed first-line therapy of antidepressants and anticonvulsants." The injured worker has marked low back pain and spasm and persistent neck pain with radiation to the shoulder and upper extremities associated with tingling and numbness of the hands. The treating physician has not documented trials of anti-depressants or anti-convulsants. The treating physician has not documented intolerance to similar medications taken on an oral basis. The criteria noted above not having been met, Flurb/Cyclo/Menth Cream 20%/10/4% 180gm is not medically necessary.