

Case Number:	CM15-0068298		
Date Assigned:	04/27/2015	Date of Injury:	03/21/1991
Decision Date:	05/22/2015	UR Denial Date:	03/17/2015
Priority:	Standard	Application Received:	04/10/2015

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: Iowa, Illinois, Hawaii

Certification(s)/Specialty: Preventive Medicine, Occupational Medicine, Public Health & General Preventive 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 57-year-old male, who sustained an industrial injury on March 21, 1991. He reported hearing a loud pop in his back. The injured worker was diagnosed as having other symptoms referable to the back, thoracic or lumbosacral neuritis or radiculitis, lumbosacral spondylosis without myelopathy, displacement of lumbar intervertebral disc displacement without myelopathy, intervertebral lumbar disc disorder with myelopathy lumbar region, headache, post-traumatic stress disorder (PTSD), displacement of intervertebral disc displacement without myelopathy unspecified site, and degeneration of thoracic or thoracolumbar intervertebral disc. Diagnostics to date has included MRI. Treatment to date has included medications including topical opioid, oral opioid, topical pain, muscle relaxant, antidepressant, anti-anxiety, antipsychotic, and anti-epilepsy. On February 3, 2015, the injured worker complains of back pain with a 6 level. He lumbar-sacral orthosis (LSO) complains of a shooting pain up his neck causing headaches. The physical exam revealed limited sitting and standing tolerance, tenderness with myospasm of the lumbar spine, multiple active trigger points, decreased sensation in the upper and lower extremities, and sciatic pattern on straight leg raise. The treatment plan includes Qvar spray (for focal allergic/irritation reaction of skin at Fentanyl patch site) and Tegaderm plus pad.

IMR ISSUES, DECISIONS AND RATIONALES

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

Qvar spray for focal allergic/irritation reaction of skin at the Fentanyl patch site: 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): 111-113. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Compound creams and Other Medical Treatment Guidelines <https://online.epocrates.com/>; QVAR MONOGRAPH.

Decision rationale: MTUS and ODG recommends usage of topical analgesics as an option, but also further details "primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed". The medical documents do not indicate failure of antidepressants or anticonvulsants. MTUS states, "There is little to no research to support the use of many of these agents. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended". QVAR is FDA approved for the treatment of Asthma and it is inhaled. It is not FDA approved for topical use. As such the request for Qvar spray for focal allergic/irritation reaction of skin at the Fentanyl patch site is not medically necessary.

Tegaderm plus pad #10 with no refills: 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): 111-113. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Compound creams and Other Medical Treatment Guidelines <https://online.epocrates.com/>; QVAR MONOGRAPH.

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