

Case Number:	CM14-0142066		
Date Assigned:	09/10/2014	Date of Injury:	07/10/2007
Decision Date:	10/22/2014	UR Denial Date:	08/11/2014
Priority:	Standard	Application Received:	09/03/2014

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. The expert reviewer is Board Certified in Physical Medicine and Rehabilitation and is licensed to practice in Illinois. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 53-year-old female who reported an injury on 07/10/2007. The mechanism of injury was not provided. Prior treatments included physical therapy, a left sided selective nerve root block and ongoing cognitive behavioral therapy. The injured worker underwent lumbar spine surgical intervention. The injured worker underwent MRIs of the cervical spine and lumbar spine. The injured worker's medications included SPRIX Nasal Spray, hydrocodone bit/APAP 10/325 mg, Meloxicam 7.5 mg, Prozac 20 mg, Dilaudid 2 mg, and tizanidine hydrochloride 4 mg. The documentation of 07/30/2014 revealed the injured worker was limping. The injured worker indicated she had numbness and tingling along the right plantar foot. The objective findings revealed the injured worker had tenderness along the groin with flexion and internal rotation causing pain. The injured worker had tenderness along the lumbar spine. Flexion was decreased, as was tilting. The deep tendon reflexes were symmetric and sensation was satisfactory in the lower limbs. The diagnoses included discogenic cervical condition with disc disease from C3-7 and discogenic lumbar condition status post hemilaminectomy from L3-S1 on the left with retrolisthesis from L1 and on H level. The treatment plan included a TENS unit, a neck pillow, lumbar support, cervical traction, Flexeril 7.5 mg, an MRI of the left hip and left knee, an adjustable chair, a hot/cold wrap, tramadol Extended Release 150 mg, Terocin 30 patches, LidoPro cream. There was no Request for Authorization submitted for the request.

IMR ISSUES, DECISIONS AND RATIONALES

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

LidoPro Cream Qty:1: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Salicylate Topicals, Topical Analgesic, Topical Capsaicin, Lidocaine Page(s): 105, 111, 28, 112.

Decision rationale: The California MTUS guidelines indicate that topical analgesics are largely experimental in use with few randomized control trials to determine efficacy or safety... are 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...Capsaicin: Recommended only as an option in patients who have not responded or are intolerant to other treatments. There have been no studies of a 0.0375% formulation of capsaicin and there is no current indication that this increase over a 0.025% formulation would provide any further efficacy. The guidelines indicate that topical lidocaine (Lidoderm) may be recommended for localized peripheral pain after there has been evidence of a trial of first-line therapy (tri-cyclic or SNRI anti-depressants or an AED such as gabapentin or Lyrica). No other commercially approved topical formulations of lidocaine (whether creams, lotions or gels) are indicated for neuropathic pain. The guidelines recommend treatment with topical salicylates. Per drugs.com, LidoPro is a topical analgesic containing capsaicin / lidocaine / menthol / methyl salicylate. The clinical documentation submitted for review failed to provide documentation of a trial and failure of antidepressants and anticonvulsants. There was a lack of documentation of exceptional factors to warrant nonadherence to guideline recommendations. The request as submitted failed to indicate the frequency and the body part to be treated with the LidoPro cream. Given the above, the request for LidoPro Cream Qty: 1 is not medically necessary.

Adjustable chair Qty:1: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee & Leg Chapter, Durable medical equipment, DME

Decision rationale: The Official Disability Guidelines indicate that durable medical equipment is recommended if there is a medical need and if the device or system meets [REDACTED] definition of durable medical equipment. Durable medical equipment would include equipment which could withstand repeated use, as in, could normally be rented and used by successive patients, is primarily and customarily used to serve a medical purpose, is generally not useful to a person in the absence of illness or injury, and is appropriate for use in the injured worker's home. The clinical documentation submitted for review failed to provide documented rationale for the request. There was a lack of documentation indicating the request met the definition of durable medical equipment. Additionally, the request as submitted failed to indicate whether the request

was for rental or purchase. Given the above, the request for Adjustable chair Qty: 1 is not medically necessary.

Hot and cold wrap: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 298.

Decision rationale: The American College of Occupational and Environmental Medicine indicate at home local applications of cold are appropriate in the first few days of an acute complaint. Thereafter, there should be applications of heat or cold. The clinical documentation submitted for review failed to provide a documented rationale for a necessity for a hot and cold wrap vs. a hot or cold pack. The request as submitted failed to indicate the type of hot and cold wrap being requested as well as whether the request was for purchase. Given the above, the request for Hot and cold wrap is not medically necessary.