MAXIMUS Federal Services

Case Number:	CM13-0035581		
Date Assigned:	12/27/2013	Date of Injury:	05/19/2008
Decision Date:	04/18/2014	UR Denial Date:	09/20/2013
Priority:	Standard	Application Received:	10/17/2013

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 Internal Medicine and Pulmonary Diseases, and is licensed to practice in California. 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 patient is a 59-year-old male with a diagnosis of status post right shoulder arthroscopy with recurrent impingement syndrome, rotator cuff tear, left shoulder tendinitis, overload pain, and cervical disc herniation with radiculitis/radiculopathy. The patient was seen on 10/14/13 with complaints of pain and discomfort in his right shoulder, pain and stiffness in his cervical spine, and pain in his lower back. The patient states that the pain is aggravated from prolonged sitting, standing, walking, bending, and twisting. The only objective findings are range of motion of the cervical spine flexion 45 degrees, extension 50 degrees, right and left lateral bending 35 degrees, with +2 spasms over the upper trapezius bilaterally.

IMR ISSUES, DECISIONS AND RATIONALES

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

PRILOSEC 20MG (1 PILL TWICE PER DAY): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 68.

Decision rationale: The California MTUS recommends the use of gastrointestinal protectants for patients who are at risk for developing gastrointestinal disturbances related to medication

usage. The patient's most recent clinical documentation does not provide an adequate assessment of the patient's gastrointestinal system to support that he is at risk for the development of gastrointestinal disturbances as a result of medication usage. Therefore, the request is non-certified.

NORCO 10/325MG (1 PILL EVERY 4-6 HOURS AS NEEDED): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 68.

Decision rationale: Per subjective findings, the patient has complaints of pain and discomfort in the right shoulder, cervical spine, and low back. There is no new objective number that the patient provided as far as the pain level at this office visit. Also, the physician did not, as part of objective exam, do a complete pain assessment as per recommended by the California MTUS guidelines for patients that are on opioids. The California MTUS guidelines recommend ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. Pain assessments should include current pain, the least reported pain over the period since last assessment, average pain, intensity of the pain after taking the opioid, how long it takes for pain relief, and how long pain relief lasts. The documentation does not reflect pain assessment. Therefore, the request is noncertified

KETOPROFEN 10%/CYCLOBENZAPRINE 3%/LIDOCAINE 5%, 120MG COMPOUNDED CREAM: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 112-113.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111-112.

Decision rationale: The California MTUS Guidelines state that topical analgesics are largely experimental in use with few randomized control trials to determine efficacy or safety. Compounded products that contain at least one drug or drug class that is not recommended, is not recommended. The California MTUS guidelines note that the efficacy of topical Ketoprofen has been inconsistent in clinical trials, and most studies are small and of short duration. Lidocaine is also noted in this compound cream. In February 2007, the FDA notified consumers and healthcare professionals of the potential hazard of the use of topical lidocaine. Also, there is no mention of the use and/or efficacy of the prescribed compounded cream. Therefore, the request is non-certified.

FLURBIPROFEN 10%, CAPSAICIN 0.25%, MENTHOL 2%, CAMPHOR 1%, 12MG COMPOUND CREAM: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 112-113.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111-112.

Decision rationale: The California MTUS Guidelines state that topical analgesics are largely experimental in use with few randomized control trials to determine efficacy or safety. Compounded products that contain at least one drug or drug class that is not recommended, is not recommended. The California MTUS guidelines state that the efficacy of topical Flurbiprofen has been inconsistent in clinical trials, and most studies are small and of short duration. Topical Capsaicin has also been recommended only as an option for patients who have not responded to or are intolerant of other treatments. Also, there is no mention of the use and/or efficacy of the prescribed compounded cream. Therefore, the request is non-certified