MAXIMUS Federal Services

Case Number:	CM13-0037025		
Date Assigned:	12/13/2013	Date of Injury:	01/17/2011
Decision Date:	02/14/2014	UR Denial Date:	09/19/2013
Priority:	Standard	Application Received:	10/21/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Internal Medicine and Cardiology, has Fellowship Trained in Cardiovascular Disease and is licensed to practice in Texas. 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 physician 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 61-year-old female who reported an injury on 01/17/2011. The mechanism of injury was not provided for review. The patient's most recent clinical examination revealed aggressively worsening pain in the left shoulder and mid-back. The examination of the thoracolumbar spinal region revealed decreased range of motion and tenderness and spasming to palpation bilaterally along the T10-L3 levels. The physical findings of the left shoulder revealed restricted range of motion secondary to pain with a positive impingement sign and positive Apley's test with tenderness over the acromioclavicular joint. The patient's diagnoses included a herniated lumbar disc with radiculitis, status post kyphoplasty at T11, left shoulder bursitis, left shoulder tendonitis, left elbow bursitis, anxiety and depression, and insomnia. The patient's treatment plan included aquatherapy, and continuation of medications.

IMR ISSUES, DECISIONS AND RATIONALES

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

Ketoprofen/Cyclobenzaprine/Lidocaine topical cream: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines in Workers' Compensation (ODG Treatment Guidelines).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Section Page(s): 111.

Decision rationale: The requested Ketoprofen/Cyclobenzaprine/Lidocaine is not medically necessary or appropriate. The clinical documentation submitted for review does not provide any evidence that the patient has any significant functional benefit from medication usage. The California Medical Treatment Utilization Schedule does not recommend the use of Ketoprofen or Lidocaine as topical agents in a cream formulation, as they are not FDA-approved for this type of treatment. Additionally, California Medical Treatment Utilization Schedule does not recommend the use of muscle relaxants such as cyclobenzaprine as topical agents. The clinical documentation submitted for review does not contain any exceptional factors to support the need to extend treatment beyond guideline recommendations. The agents of the requested compound are not supported by guideline recommendations. The continued use would not be indicated. As such, the requested Ketoprofen/Cyclobenzaprine/Lidocaine cream is not medically necessary or appropriate.

Flurbirpofen topical cream: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines in Workers' Compensation (ODG Treatment Guidelines).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Section Page(s): 111.

Decision rationale: The requested Flurbiprofen is not medically necessary or appropriate. The clinical documentation submitted for review does not provide any evidence that the patient has any functional benefit or pain relief from the prescribed medication schedule. The California Medical Treatment Utilization Schedule does recommend the use of Flurbiprofen as a topical analgesic when there is evidence that the patient is intolerant, or that oral formulations are contraindicated of the patient. The clinical documentation submitted for review does provide evidence that the patient does take oral formulations of anti-inflammatories. The efficacy of these oral formulations was not determined within the documentation. Therefore, continued use of Flurbiprofen is not indicated. As such, the requested Flurbiprofen is not medically necessary or appropriate.

Capsaicin/Menthol topical cream: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines in Workers' Compensation (ODG Treatment Guidelines).

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

Decision rationale: The requested Capsaicin/Menthol topical cream is not medically necessary or appropriate. The California Medical Treatment Utilization Schedule recommends the use of topical Capsaicin only in the event that a patient is intolerant to other types of treatments to include oral analgesics. The clinical documentation submitted for review does not provide any evidence that the patient is intolerant of oral analgesics. As such, the requested Capsaicin/Menthol topical cream is not medically necessary or appropriate.