

Case Number:	CM13-0038487		
Date Assigned:	12/18/2013	Date of Injury:	03/15/2005
Decision Date:	02/05/2014	UR Denial Date:	09/26/2013
Priority:	Standard	Application Received:	09/30/2013

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 Anesthesiology and Pain Management and is licensed to practice in Florida. 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 employee reported an injury on 3/15/05. The employee is currently diagnosed with status post partial medial and lateral meniscectomy with chondroplasty and synovectomy in the right knee, lumbar degenerative disc disease, depression, left shoulder impingement syndrome, insomnia, cervical degenerative disc disease, status post right carpal tunnel release, status post anterior cervical discectomy and fusion at C5-7, and status post arthroscopic subacromial decompression with distal claviclectomy on 3/29/13. On 8/22/13, the employee reported 9/10 low back pain, 7/10 neck pain, 6/10 right shoulder pain, and 8/10 left shoulder and left wrist pain. Physical examination revealed diminished range of motion of the left shoulder, diminished grip strength, and positive straight leg raise on the right. –

IMR ISSUES, DECISIONS AND RATIONALES

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

Ketoprofen/gabapentin/tramadol topical cream: Upheld

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

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

Decision rationale: The guidelines state topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. They are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. There is a lack of documentation of the employee's failure to respond to first-line oral medications prior to the initiation of a topical analgesic. Gabapentin is not recommended as there is no peer-reviewed literature to support its use in this setting. The guidelines state any compounded product that contains at least one drug that is not recommended is not recommended as a whole. Therefore, the requested ketoprofen/gabapentin/tramadol topical cream is not medically necessary and appropriate.