

Case Number:	CM13-0044728		
Date Assigned:	12/27/2013	Date of Injury:	11/29/2010
Decision Date:	02/21/2014	UR Denial Date:	10/22/2013
Priority:	Standard	Application Received:	11/01/2013

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 Physical Medicine and Rehabilitation, has a subspecialty in Pain Management 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 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:

This is a male patient with a date of injury of 11/29/10. A utilization review determination dated 10/22/13 recommends non-certification of Flurbiprofen gel, Ketoprofen/Ketamine gel, and gabapentin/cyclobenzaprine/capsaicin gel. Norco was modified from #60 to #43. A progress report dated 10/7/13 identifies subjective complaints including low back pain 5/10 and left shoulder pain. Objective examination findings identify improvement in back and shoulder range of motion with full shoulder ROM (Range Of Motion). Patient described trigger points to the lumbar spine. Diagnoses include protrusion lumbosacral spine at L3-4 and L5-S1 with radiculitis/radiculopathy, s/p (status post) left shoulder arthroscopy on 2/22/13, and lumbar spine myofascial pain syndrome. Treatment plan recommends Norco, flurbiprofen gel, ketoprofen/ketamine gel, and gabapentin/cyclobenzaprine/capsaicin gel.

IMR ISSUES, DECISIONS AND RATIONALES

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

Norco 10/325mg #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 76-79.

Decision rationale: Regarding the request for Norco, California Pain Medical Treatment Guidelines state that Norco is an opiate pain medication. Due to high abuse potential, close follow-up is recommended with documentation of analgesic effect, objective functional improvement, side effects, and discussion regarding any aberrant use. Guidelines go on to recommend discontinuing opioids if there is no documentation of improved function and pain. Within the documentation available for review, there is no indication that the Norco is improving the patient's function or pain, no documentation regarding side effects, and no discussion regarding aberrant use. In the absence of such documentation, the currently requested Norco 10/325mg#60 is not medically necessary or appropriate.

Flurbiprofen 20% gel 120gm: 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: Regarding the request for Flurbiprofen gel, California MTUS cites that topical NSAIDs are indicated for "Osteoarthritis and tendinitis, in particular, that of the knee and elbow or other joints that are amenable to topical treatment: Recommended for short-term use (4-12 weeks). There is little evidence to utilize topical NSAIDs for treatment of osteoarthritis of the spine, hip or shoulder. Neuropathic pain: Not recommended as there is no evidence to support use. Within the documentation available for review, there is no documentation that the treatment is intended for the short-term management of osteoarthritis and/or tendinitis of joints amenable to topical treatment. There is also no clear rationale for the use of topical treatment rather than the FDA-approved oral form for this patient. In light of the above issues, the currently requested flurbiprofen is not medically necessary or appropriate .

Ketoprofen 20% 120gm/Ketamine 10% gel 120gm: 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: Regarding the request for ketoprofen/ketamine gel, California MTUS cites that topical NSAIDs are indicated for "Osteoarthritis and tendinitis, in particular, that of the knee and elbow or other joints that are amenable to topical treatment: Recommended for short-term use (4-12 weeks). There is little evidence to utilize topical NSAIDs for treatment of osteoarthritis of the spine, hip or shoulder. Neuropathic pain: Not recommended as there is no evidence to support use. Within the documentation available for review, there is no documentation that the treatment is intended for the short-term management of osteoarthritis and/or tendinitis of joints amenable to topical treatment. Additionally, topical ketoprofen is "not currently FDA approved for a topical application. It has an extremely high incidence of photocontact dermatitis." Topical

ketamine is "Only recommended for treatment of neuropathic pain in refractory cases in which all primary and secondary treatment has been exhausted." This has also not been documented. Finally, there is also no clear rationale for the use of topical treatment rather than the FDA-approved oral form for this patient. In light of the above issues, the currently requested ketoprofen/ketamine gel is not medically necessary or appropriate .

Gabapentin 10%/ Cyclobenzaprine 10%/Capsaicin 0.0375% 120gm: 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: Regarding the request for gabapentin/cyclobenzaprine/capsaicin, California MTUS cites that topical capsaicin is "Recommended only as an option in patients who have not responded or are intolerant to other treatments." Within the documentation available for review, there is no documentation of lack of response and/or intolerance to all other treatments. Additionally, the California MTUS specifically recommends against the topical use of both gabapentin and cyclobenzaprine. In light of the above issues, the currently requested gabapentin/cyclobenzaprine/capsaicin is not medically necessary or appropriate.