

Case Number:	CM13-0045014		
Date Assigned:	12/27/2013	Date of Injury:	05/13/2008
Decision Date:	02/27/2014	UR Denial Date:	10/22/2013
Priority:	Standard	Application Received:	10/31/2013

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 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 was a 34 year old male with complaints of left shoulder, left elbow and low back pain resulting from an injury 05/13/2008. The patient had a spinal fusion surgery noted on 11/06/2013 MRI. The patient was seen on 11/20/2013 which noted the patient to have continued pain to his low back, and shoulder. The patient was treated with an injection of Toradol and Marcaine. The patient had noted dysesthesia to L5 and S1 dermatomes. It was further noted the patient had weakness to his ankles and feet. The patient was treated with ESIs on 12/09/2013.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retro Cyclo/Caps/Lid/Ketop: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-112.

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

Decision rationale: The request for Retro Cyclo/Caps/Lid/Ketop is non-certified. The California MTUS guidelines do not recommend the use of topical analgesics that contain muscle relaxants. Cyclobenzaprine is a muscle relaxant. It is further noted the documentation submitted for review did not address the indication for topical analgesics. The guidelines do not recommend the use of

ketoprofen as this agent is not currently FDA approved for a topical application. The patient was noted to have left shoulder and low back pain upon examination on 11/20/2013. However, the documentation submitted for review indicated the treatment plan was noted as surgical intervention. Given the information submitted for review the request for Retro Cyclo/Caps/Lid/Ketop is non-certified.

Retro Ketop/Lidoc/Cap/Tram: Upheld

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

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

Decision rationale: The request for Retro Ketop/Lidoc/Cap/Tram is non-certified. The California MTUS guidelines do not recommend the use of topical analgesics that contain opioids. Tramadol is an opioid. It is further noted the documentation submitted for review did not address the indication for topical analgesics. The guidelines do not recommend the use of ketoprofen as this agent is not currently FDA approved for a topical application. The patient was noted to have left shoulder and low back pain upon examination on 11/20/2013. However, the documentation submitted for review indicated the treatment plan was noted as surgical intervention. Given the information submitted for review the request for Retro Ketop/Lidoc/Cap/Tram is non-certified.