

Case Number:	CM13-0069552		
Date Assigned:	01/03/2014	Date of Injury:	03/04/2013
Decision Date:	05/30/2014	UR Denial Date:	12/19/2013
Priority:	Standard	Application Received:	12/23/2013

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 Physical Medicine & 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 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 injured worker is a 28-year-old female who reported an injury on 03/04/2013. The mechanism of injury was not stated. The current diagnosis is bilateral carpal tunnel syndrome. The injured worker was evaluated on 10/21/2013. The injured worker reported 8/10 bilateral wrist and hand pain with radiation, numbness, and tingling. Current medications include topical creams. Physical examination revealed mild tenderness to palpation of bilateral wrists, positive Tinel's and Phalen's testing, and decreased sensation in bilateral median nerve sensory distributions. X-rays obtained in the office on that date indicated no evidence of fractures or dislocations. Treatment recommendations included continuation of compounded creams.

IMR ISSUES, DECISIONS AND RATIONALES

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

RETROSPECTIVE CONTAINER OF GABAPENTIN 10%/CYCLOBENZAPRINE 10%/CAPSAICIN 0.0375% 120 GRAMS: 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 MTUS Chronic Pain Guidelines state topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. Any compounded product that contains at least 1 drug that is not recommended is not recommended as a whole. Gabapentin is not recommended as there is no evidence for the use of any anti-epilepsy drug as a topical product. Muscle relaxants are also not recommended. Therefore, the request cannot be determined as medically appropriate. There is also no frequency listed in the current request. As such, the request is not medically necessary and appropriate.

RETROSPECTIVE CONTAINER OF COMPOUNDED FLURBIPROFEN 20% GEL 120 GRAMS: 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 MTUS Chronic Pain Guidelines state the only FDA approved topical NSAID is Diclofenac. MTUS Chronic Pain Guidelines further indicate that any compounded product that contains at least 1 drug that is not recommended is not recommended as a whole. Therefore, the current request cannot be determined as medically appropriate. There is also no frequency listed in the current request. As such, the request is not medically necessary and appropriate.

RETROSPECTIVE CONTAINER OF KETOPROFEN 20%/KETAMINE 10% GEL 120 GRAMS: Upheld

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

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

Decision rationale: The MTUS Chronic Pain Guidelines state topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. Any compounded product that contains at least 1 drug that is not recommended is not recommended as a whole. The only FDA approved topical NSAID is Diclofenac. MTUS Chronic Pain Guidelines do not recommend Ketamine. Therefore, the current request cannot be determined as medically appropriate. There is also no frequency listed in the current request. As such, the request is not medically necessary and appropriate.