

Case Number:	CM13-0069762		
Date Assigned:	01/03/2014	Date of Injury:	04/20/1999
Decision Date:	06/12/2014	UR Denial Date:	11/22/2013
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 Anesthesiology, has a subspecialty in Pain Management and is licensed to practice in California and Nevada. 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 63 year old female who sustained an injury on 04/20/99. The injured worker has had an extensive history of surgical procedures to include multiple cervical fusions as well as right shoulder procedures. The injured worker has been also followed for osteoarthritis in the right shoulder and was considering further surgery to include shoulder arthroplasty. The injured worker had been followed by [REDACTED] for ongoing chronic pain. The injured worker's prior medications have included multiple narcotics for pain. The injured worker was seen by [REDACTED] on 11/20/13. [REDACTED] noted the injured worker's pain was at 7/10 on the VAS. On physical examination, there was mild weakness and numbness in a right L5 distribution in the lower extremities. The injured worker did ambulate with an antalgic gait. There was decreased range of motion in the cervical spine as well as at the lumbar spine. Positive impingement signs in the right shoulder were noted with marked decreased range of motion.

IMR ISSUES, DECISIONS AND RATIONALES

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

KETAMINE/CLONIDINE/GABAPENTIN/FLURBRIPROFEN/LIDOCAINE: Upheld

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

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

Decision rationale: In regards to the use of a topical compounded medication that includes Ketamine, Lidocaine, Clonidine, Gabapentin, and Flurbiprofen; this reviewer would not have recommended this medication as medically necessary based on the clinical documentation provided for review and current evidence based guideline recommendations. The CA MTUS Chronic Pain Treatment Guidelines and US FDA note that the efficacy of compounded medications has not been established through rigorous clinical trials. The FDA requires that all components of compounded topical medication be approved for transdermal use. This compound contains Ketamine, Clonidine, Gabapentin, and Flurbiprofen which are not approved for transdermal use. The clinical documentation provided did not discuss the claimant's prior medication use and did not indicate that there were any substantial side effects with the oral version of the requested medication components. Therefore, this compound would not have been supported as medically necessary.