

Case Number:	CM13-0070547		
Date Assigned:	01/08/2014	Date of Injury:	03/13/2013
Decision Date:	05/30/2014	UR Denial Date:	12/20/2013
Priority:	Standard	Application Received:	12/20/2013

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 and Rehabilitation has a subspecialty in Pain Management 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 40 year old male with a reported date of injury on 03/13/2013. The injury occurred when the injured worker was involved in a single vehicle semi motor vehicle collision. The diagnoses noted within the progress note dated 01/15/2013 included head concussion/loss of consciousness, traumatic brain injury, cervical spine sprain/strain, thoracic spine sprain/strain, thoracic spine disc herniation 3mm at T2-T3, and lumbar spine disc herniation 4mm at L4-L5 and 3mm at L5-S1. The progress note from that date also stated the injured worker had pain to the upper back 3/10 which was intermittent; otherwise there were no other complaints or concerns. The request for authorization form was not submitted with the medical records.

IMR ISSUES, DECISIONS AND RATIONALES

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

KETOPROFEN/CYCLOBENZAPRINE/LIDOCAINE 10 PERCENT/5 PERCENT (120 GMS): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 105,111-113.

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

Decision rationale: The request for Ketoprofen/Cyclobenzaprine/Lidocaine 10 percent/5 percent (120gms) is medically necessary. The injured worker has been going to chiropractic therapy and acupuncture as well as using medications. The Chronic Pain Medical Treatment guidelines states there is little to no research to support the use of many of these agents. Any compounded product that contains at least one drug or (drug class) that is not recommend is not recommended. Ketoprofen is not currently FDA approved for a topical application. It has an extremely high incidence of photocontact dermatitis. Topical treatment can result in blood concentrations and systemic effect comparable to those from oral forms and caution should be used for patients at risk, including those with renal failure. Lidocaine is recommended for neuropathic pain after there has been evidence of a trial of first-line therapy. Topical Lidocaine, in the formulations of a dermal patch (Lidoderm) has been designated for orphan status by the FDA for neuropathic pain. No other commercially approved topical formulations of Lidocaine (whether creams, lotions, or gels) are indicated for neuropathic pain. The guidelines note there is no evidence for use of any other muscle relaxant as a topical product. As the guidelines do not recommend the use of topical Lidocaine in forms other than Lidoderm and topical muscle relaxants are not indicated for topical use the requested cream would not be indicated. Therefore, the request is not medically necessary.

FLURBIPROFIEN/CAPSAISIN/MENTHOL 10/0.25/2/1 PERCENT (120 GMS): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TOPICAL ANALGESICS Page(s): 105,111-113.

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

Decision rationale: The request for Flurbiprofen/Capsaicin/Menthol 10/0.25/2/1 is medically necessary. The injured worker has been going to chiropractic therapy and acupuncture as well as using pain medications. The Chronic Pain Medical Treatment guidelines state the efficacy in clinical trials for (NSAIDs) non-steroidal anti-inflammatory drugs topical has been inconsistent and most studies are small and of short durations. Topical NSAIDs have been shown in meta-analysis to be superior to placebo during the first 2 weeks of treatment for osteoarthritis, but either not afterward, or with a diminishing effect over another 2-week period. There is no evidence to support the use of topical NSAID for neuropathic pain. The guidelines also recommend Capsaicin only as an options in injured workers who have not responded or are intolerant to other treatments. There are positive randomized studies with Capsaicin cream in injured workers with osteoarthritis, fibromyalgia, and chronic non-specific back pain. There was a lack of documentation indicating the injured worker had a diagnosis which would indicate the need for the topical medication. There also was a lack of documentation of this medication being taken or prescribed submitted for review; the requesting physician's rationale for the request was unclear. Therefore, the request is not medically necessary.