

Case Number:	CM13-0072142		
Date Assigned:	01/08/2014	Date of Injury:	08/08/2009
Decision Date:	08/07/2014	UR Denial Date:	12/13/2013
Priority:	Standard	Application Received:	12/30/2013

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 Occupational Medicine 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 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:

This is a 60-year-old female who sustained injury on 08/08/2009 to her wrists, neck and lower back while performing repetitive duties at work of preparing food items and cleaning. Treatment history includes medications and physical therapy. She had x-rays of the left wrist dated 09/10/2009 which demonstrated probable mild joint space narrowing radiocarpal joint. X-rays of the right wrist dated 09/10/2009 showed questionable lucency overlying the radial styloid probably fracture. A note dated 04/09/2010 indicates that she reported gradual improvement of neck and lower back pain symptoms. Her pain radiates to the legs at times with increased activity. She complained of bilateral hand and wrist pain with numbness and tingling. Objective findings include restricted ROM with palpable tenderness of the lumbar spine. She has positive straight leg raise; Decreased grip strength; Positive Tinel's of bilateral wrists. Diagnoses were cervical and lumbar spine disc protrusion, lumbar spine radiculopathy, bilateral carpal tunnel syndrome, anxiety, and insomnia. She was instructed to continue work conditioning and follow-up with an orthopedic surgeon for possible carpal tunnel release. There are no current reports for review. Prior utilization review dated 12/13/2013 states the requests for retrospective request for ketamine/ketoprofen dispensed on 4/16/10 and retrospective request for Cyclobenzaprine/Gabapentin dispensed on 4/16/10 are not certified as they are not supported by the guidelines.

IMR ISSUES, DECISIONS AND RATIONALES

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

RETROSPECTIVE MEDICATION KETAMINE/KETOPROFEN (DISPENSED 4/16/2010), DURATION AND FREQUENCY UNKNOWN, FOR THE BILATERAL WRISTS AND LUMBAR SPINE: 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): 111-113.

Decision rationale: As per CA MTUS guidelines, topical ketamine is currently under study and is only recommended for treatment of neuropathic pain and refractory cases in which all primary and secondary treatment has been exhausted. While ketoprofen is not currently FDA approved for topical applications as it has an extremely high incidence of photocontact dermatitis. Further guidelines indicate that any product that contains at least one drug (or drug class) that is not recommended is not recommended. Thus, the request for the Ketamine/Ketoprofen is not medically necessary.

RETROSPECTIVE MEDICATION CYCLOBENZAPRINE/GABAPENTIN (DISPENSED 4/16/2010), DURATION AND FREQUENCY UNKNOWN, FOR TREATMENT OF THE BILATERAL WRISTS AND LUMBAR SPINE: 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): 111-113.

Decision rationale: As per CA MTUS guidelines, topical gabapentin is not recommended as there is no peer-reviewed literature to support the use. Further guidelines indicate that any product that contains at least one drug (or drug class) that is not recommended is not recommended. Thus, the request for the Cyclobenzapine/Gabapentin is not medically necessary.