

Case Number:	CM13-0072230		
Date Assigned:	01/17/2014	Date of Injury:	05/21/2003
Decision Date:	06/02/2014	UR Denial Date:	12/18/2013
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 Preventive 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:

According to the records made available for review, this is a 67-year-old male with a 5/21/13 date of injury. At the time (12/11/13) of request for authorization for prospective request for 1 prescription of Flexeril 10mg #60 between 12/11/2013 and 02/14/2014, prospective request for 1 prescription of Voltaren gel 1% 100gm #5 between 12/11/2013 and 02/14/2014, and prospective request for 1 prescription of Kohana #10 formula between 12/11/2013 and 02/14/2014, there is documentation of subjective (change in condition which has increased the need for Voltaren cream, gastrointestinal upset with use of oral NSAID's, daily use of cream increased function and decreases pain level, Vicodin has decreased to 2-12/week and varies with pain level, and Flexeril 3/week if feeling neck spasms) and objective (4/5 strength on the left, limited end point range of motion of shoulders, and tenderness to palpation in scapular region) findings, current diagnoses (closed fracture skull/face and disorder of cervical region), and treatment to date (medications (including ongoing treatment with Vicodin, Flexeril, and Voltaren gel since at least 3/13/13)). Medical report identifies a request to re-start Voltaren gel to the left first digit for anti-inflammatory effects. Regarding prospective request for 1 prescription of Flexeril 10mg #60 Final Determination Letter for IMR Case Number CM13-0072230 3 between 12/11/2013 and 02/14/2014, there is no documentation of acute muscle spasm, the intention to treat over a short course (less than two weeks), and functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications as a result of Flexeril use to date. Regarding prospective request for 1 prescription of Voltaren gel 1% 100gm #5 between 12/11/2013 and 02/14/2014, there is no documentation of osteoarthritis pain in joints that lend themselves to topical treatment (ankle, elbow, foot, hand, knee, and wrist) and the intention to treat over short-term course (4-12 weeks).

IMR ISSUES, DECISIONS AND RATIONALES

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

PROSPECTIVE REQUEST FOR 1 PRESCRIPTION OF FLEXERIL 10MG #60 BETWEEN 12/11/2013 AND 02/14/2014: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Cyclobenzaprine (Flexeril) Section, Page(s): 41-42. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Chapter, Muscle Relaxant Section.

Decision rationale: The Chronic Pain Medical Treatment Guidelines identifies that Flexeril is recommended for a short course of therapy. MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. The Official Disability Guidelines (ODG) identifies that muscle relaxants are recommended as a second line option for short-term (less than two weeks) treatment of acute low back pain and for short-term treatment of acute exacerbations in patients with chronic low back pain. Within the medical information available for review, there is documentation of diagnoses of closed fracture skull/face and disorder of cervical region. In addition there is documentation of ongoing treatment with Flexeril since at least 3/13/13, used when feeling neck spasm. However, there is no documentation of acute muscle spasm. In addition, given documentation of records reflecting prescriptions for Flexeril since at least 3/13/13, there is no documentation of the intention to treat over a short course (less than two weeks). Furthermore, there is no documentation of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications as a result of Flexeril use to date. Therefore, based on guidelines and a review of the evidence, the request for prospective request for Flexeril 10mg # is not medically necessary.

PROSPECTIVE REQUEST FOR 1 PRESCRIPTION OF VOLTAREN GEL 1% 100GM #5 BETWEEN 12/11/2013 AND 02/14/2014: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesic Section, Page(s): 111-112. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Chapter, Diclofenac Section.

Decision rationale: The Chronic Pain Medical Treatment Guidelines identifies documentation of osteoarthritis pain in joints that lend themselves to topical treatment (ankle, elbow, foot, hand, knee, and wrist) and short-term use (4-12 weeks), as criteria necessary to support the medical necessity of Voltaren Gel 1%. In addition, MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a

reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. The Official Disability Guidelines (ODG) identifies documentation of failure of an oral NSAID or contraindications to oral NSAIDs, as criteria necessary to support the medical necessity of Voltaren Gel. Within the medical information available for review, there is documentation of diagnoses of closed fracture skull/face and disorder of cervical region. In addition, there is documentation of ongoing treatment with Voltaren gel since at least 3/13/13, that change in condition has increased the need for Voltaren cream, gastrointestinal upset with use of oral NSAID's, that daily use of cream increased function and decreases pain level, and a request to re-start Voltaren gel to the left first digit for anti-inflammatory effects. However, there is no documentation of osteoarthritis pain in joints that lend themselves to topical treatment (ankle, elbow, foot, hand, knee, and wrist). In addition, given documentation of records reflecting prescriptions for Voltaren gel since at least 3/13/13, there is no documentation of the intention to treat over short-term course (4-12 weeks). Therefore, based on guidelines and a review of the evidence, the request for prospective request for 1 prescription of Voltaren gel 1% 100gm #5 between 12/11/2013 and 02/14/2014 is not medically necessary.

PROSPECTIVE REQUEST FOR 1 PRESCRIPTION OF KOHANA #10 FORMULA BETWEEN 12/11/2013 AND 02/14/2014: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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

Decision rationale: An online search identifies [REDACTED] specializing in custom compounded medications. MTUS Chronic Pain Medical Treatment Guidelines identifies that many agents are compounded as monotherapy or in combination for pain control; that Ketoprofen, lidocaine (in creams, lotion or gels), capsaicin in a 0.0375% formulation, Baclofen and other muscle relaxants, and Gabapentin and other antiepilepsy drugs are not recommended for topical applications; and that any compounded product that contains at least one drug (or drug class) that is not recommended, is not recommended. Within the medical information available for review, there is documentation of diagnoses of closed fracture skull/face and disorder of cervical region. However, despite the lack of recommendations and/or the specific ingredients of the requested Kohana #10 formula, there is documentation that [REDACTED] specialized in custom compounded medications. Therefore, based on guidelines and a review of the evidence, the request for prospective request for 1 prescription of Kohana formula #10 between 12/11/2013 and 02/14/2014 is not medically necessary.