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| Case Number: | CM14-0000807 | | |
| Date Assigned: | 01/17/2014 | Date of Injury: | 03/02/2009 |
| Decision Date: | 06/11/2014 | UR Denial Date: | 12/11/2013 |
| Priority: | Standard | Application Received: | 01/02/2014 |

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 Illinois. 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 56 year old male who reported a low back injury on 03/02/2009. The mechanism of injury was not indicated within the medical records provided for review. The clinical note dated 10/28/2013 noted the injured worker reported right sided low back pain rated 6/10 with radiation into the right lower extremity. The physical exam noted a negative straight leg raise test and the rest of the physical exam noted unremarkable findings. The diagnoses included right trochanteric bursitis post-operative and the last diagnosis was unable to be read from the scanned copy. The request for authorization was dated 12/28/2013.

IMR ISSUES, DECISIONS AND RATIONALES

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

FLURBIPROFEN 20% GEL 120GM: 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): 111-112.

Decision rationale: The MTUS Chronic Pain Guidelines state NSAID creams are indicated for osteoarthritis and tendinitis, in particular, that of the knee and elbow or other joints that are amenable to topical treatment. In addition, MTUS Chronic Pain Guidelines further indicate that

NSAID efficacy in clinical trials for this treatment modality has been inconsistent and most studies are small and of short duration. The injured worker did not show a diagnosis that would be indicated for use by the medication. Furthermore, there was a lack of documentation as to why the injured worker was unable to utilize oral medications. Thus, the request is not medically necessary and appropriate.

KETOPROFEN 20% KETAMINE 10% GEL 120GM: 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): 111-112.

Decision rationale: The MTUS Chronic Pain Guidelines state Ketoprofen is not currently FDA approved for a topical application. It has an extremely high incidence of photocontact dermatitis. In addition, the MTUS Chronic Pain Guidelines state Ketamine is still under study and only recommended for treatment of neuropathic pain in refractory cases in which all primary and secondary treatment has been exhausted. Topical Ketamine has only been studied for use in non-controlled studies for CRPS I and post-herpetic neuralgia and both have shown encouraging results. The injured worker lacks a diagnosis to support an indication for Ketamine, and Ketoprofen is not a FDA approved topical agent. Furthermore, there was a lack of documentation as to why the injured worker was unable to utilize oral medications. Thus, the request is not medically necessary and appropriate.

GABAPENTIN 10%,CYCLOBENZAPRINE 10%, CAPSAICIN 0.0375% 120GM: 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 Capsaicin is generally available as a 0.025% formulation (as a treatment for osteoarthritis) and a 0.075% formulation (primarily studied for post-herpetic neuralgia, diabetic neuropathy and post-mastectomy pain). There have been no studies of a 0.0375% formulation of Capsaicin and there is no current indication that this increase over a 0.025% formulation would provide any further efficacy. In addition, the MTUS Chronic Pain Guidelines state Gabapentin topically is not recommended and neither are other muscle relaxants. The MTUS Chronic Pain Guidelines indicate that any compounded drug that contains one drug that is not recommended is therefore not recommended as a whole. Thus, the request is not medically necessary and appropriate.