

Case Number:	CM14-0004003		
Date Assigned:	03/03/2014	Date of Injury:	08/22/2002
Decision Date:	06/30/2014	UR Denial Date:	12/16/2013
Priority:	Standard	Application Received:	01/09/2014

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 and 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 50 year old female who reported an injury on 08/22/2002. Per the clinical note dated 12/10/2013 the injured worker reported headaches, dizziness, and frequent neck pain rated 7/10 with radiation to the bilateral upper extremities with occasional numbness and tingling. The injured worker also reported right shoulder pain rated 8/10, left shoulder pain rated 6/10, low back pain rated 7/10 with radiation to the bilateral buttocks and hips, and right knee pain rated 5/10 with popping. Upon physical exam the injured worker was noted to have severely restricted cervical spine range of motion with spasms and a positive compression test. She had severe hyperreflexia in the upper and lower bilateral extremities. The injured worker was also reported to have a positive Hoffman's test on the left and a positive Romberg's test bilaterally. The diagnoses for the injured worker included herniated nucleus pulposus at C5-C6, temporomandibular disorder, right shoulder impingement syndrome, right knee internal derangement, fibromyalgia, chronic fatigue syndrome, and lumbar spine herniated nucleus pulposus at L4-L5. The request for authorization for medical treatment was dated 09/24/2013.

IMR ISSUES, DECISIONS AND RATIONALES

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

MAPROSYN GEL TABLETS, 1 PO BID #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NON-STEROIDAL ANTI-INFLAMMATORY DRUGS (NSAIDS) Page(s): 66.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAID's, Naproxen Page(s): 66-67.

Decision rationale: Per the CA MTUS guidelines Naproxen is a nonsteroidal anti-inflammatory drug (NSAID) recommended for the relief of the signs and symptoms of osteoarthritis. NSAID's are recommended to be taken at the lowest dose for the shortest period in injured workers with moderate to severe pain and for acute exacerbations of chronic low back pain as an option for short-term symptomatic relief. NSAID's are recommended as a second-line treatment after acetaminophen. In general, there is conflicting evidence that NSAIDs are more effective than acetaminophen for acute LBP. The guidelines recommend NSAID's for short term treatment; however, per the documentation the injured worker has been utilizing this medication long-term. There is a lack of documentation regarding the efficacy of this medication for the injured worker. Therefore, the request for maprosyn gel tablets 1 PO BID #60 is not medically necessary and appropriate.

██████████ **HEAT WRAP 1 QD 12 BOXES:** Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 298.

Decision rationale: ACOEM guidelines state at-home local applications of cold in first few days of acute complaint; thereafter, applications of heat or cold are recommended for low back disorders. The official Disability Guidelines state there is moderate evidence that heat wrap therapy provides a small short-term reduction in pain and disability in acute and sub-acute low-back pain, and that the addition of exercise further reduces pain and improves function. The documentation provided indicated the injured worker's pain was chronic in nature, the guidelines recommend heat for use with acute or sub-acute low back pain. In addition, the site at which the wraps are to be applied was not specified within the request. Therefore, the request for ██████████ ██████████ heat wraps 1 QD 12 boxes is not medically necessary and appropriate.

FLURBIROFEN 20 % GEL 120 MG, KETOPROFEN 20% +KETAMINE 10% GEL 120 GM AND GABSPENTIN 10%+ CYCLOBENZAPRINE 10% WITH 0.375% CAPSNCIN 120 GM: Upheld

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

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

Decision rationale: Per the CA MTUS guidelines topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. Topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed, there is little to no research to support the use of many of these agents. The

guidelines note any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. The efficacy of NSAID's in clinical trials for this treatment modality has been inconsistent and most studies are small and of short duration. Ketoprofen is not currently FDA approved for topical application as it has an extremely high incidence of photocontact dermatitis. Capsaicin studies do not indicate the 0.0375% formulation would provide any further efficacy then the 0.025% formulation. Gabapentin is not recommended for topical use. There is no evidence for use of cyclobenzaprine or any other muscle relaxant for topical application. The guidelines clearly state that any compounded product that contains one or more drug or drug class that is not recommended for topical use is not recommended. The guidelines note studies pertaining to capsaicin 0.0375% do not show further efficacy with the stronger percentage. Ketoprofen is not currently approved for topical use. The guidelines do not recommend the use of gabapentin and cyclobenzaprine for topical application. Therefore, the request for flurbiprofen 20% gel 120mg, ketoprofen 20% + ketamine 10% gel 120gm and gabapentin 10% + cyclobenzaprine 10% with 0.375% capsaicin 120 gm is non-medically necessary and appropriate.