

Case Number:	CM14-0004460		
Date Assigned:	02/05/2014	Date of Injury:	12/06/2011
Decision Date:	06/30/2014	UR Denial Date:	12/12/2013
Priority:	Standard	Application Received:	01/13/2014

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 60-year-old male who reported an injury on 12/06/2011 secondary to an unknown mechanism of injury. His diagnoses include cervical discopathy with radiculitis, lumbar discopathy with radiculitis, carpal tunnel syndrome, right hip greater trochanteric bursitis, internal derangement of the bilateral knees, left knee medial meniscus tear, and bilateral ulnar neuropathy. The injured worker was evaluated on 12/02/2013 and reported persistent neck pain and low back pain. On physical examination, the injured worker was noted to have tenderness to palpation of the cervical paravertebral muscles and upper trapezial muscles with spasm. He was also noted to have a positive axial loading compression test and Spurling's maneuver. The physical examination also revealed tenderness to the lumbar paravertebral muscles with a positive seated nerve root test. Additionally, the injured worker was noted to have tenderness to at the left knee joint line with a positive McMurray's sign. The injured worker was recommended for a left knee surgery and continued medications. A Request for Authorization was submitted on 12/04/2013 for 2 topical sprays with 3 refills for each.

IMR ISSUES, DECISIONS AND RATIONALES

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

KETOP/LIDOC/CAP/TRAM 15%, 1%, 0.0125%, 5% 120 ML SPRAY WITH THREE (3) REFILLS FOR DOS 12/4/2013: Upheld

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

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

Decision rationale: The California MTUS Guidelines state that topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. These guidelines state that topical Ketoprofen has an extremely high incidence of photo contact dermatitis and is not currently FDA-approved for topical application. Additionally, Lidoderm is the only topical formulation of lidocaine currently supported by the evidence-based guidelines. Furthermore, the guidelines state that any compounded product that contains at least 1 drug (or drug class) that is not recommended, is not recommended. The requested medication contains at least 2 drugs that are not recommended. Moreover, the request as written is for 3 refills which does not allow for timely re-assessment of medication efficacy. As such, the request for (Ketoprofen 15% / lidocaine 1% / capsaicin 0.0125% / tramadol 5%) 120 mL spray with 3 refills for date of service 12/04/2013 is not medically necessary and appropriate.

CYCLO/CAPS/LIDO/FLURB 2%, 0.0125%, 1%, 10% 120ML SPRAY WITH THREE (3) REFILLS FOR DOS 12/4/2013: Upheld

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

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

Decision rationale: The California MTUS Guidelines state that topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. These guidelines state that there is no evidence for use of muscle relaxants such as cyclobenzaprine in a topical formulation. Additionally, Lidoderm is the only topical formulation of lidocaine recommended by the evidence-based guidelines. Furthermore, the guidelines state that any compounded product that contains at least 1 drug (or drug class) that is not recommended, is not recommended. The requested medication contains at least 2 drugs that are not recommended. Moreover, the request as written is for 3 refills which does not allow for timely re-assessment of medication efficacy. As such the request for (cyclobenzaprine 2% / capsaicin 0.0125% / lidocaine 1% / flurbiprofen 10%) 120 mL spray with 3 refills for date of service 12/04/2013 is not medically necessary and appropriate.