MAXIMUS Federal Services

Case Number:	CM14-0004611		
Date Assigned:	06/11/2014	Date of Injury:	11/18/2011
Decision Date:	07/18/2014	UR Denial Date:	12/20/2013
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 & Rehabilitation and is licensed to practice in Illionis. 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 36 year old male who reported an injury on 02/20/2013 while pushing a cart that weighed 60 pounds. The injured worker had a history of neck pain that was off and on and unchanged the injury. The injured worker stated that is radiating pain and numbness to the bilateral lower extremities. There was shoulder elbow and wrist pain all the time that had not changed since injury. Upon examination on 11/16/2013, the injured worker the injured worker had extension 45 degrees, right lateral rotation 65 degrees, left lateral rotation 65 degrees, right lateral bend 50 degrees, left lateral bend 50 degrees. active range of motion revealed bilaterally forward flexion 180 degrees, side abduction 180 degrees, extension 60 degrees, external rotation 90 degrees, internal rotation 90 degrees, and adduction 30 degrees. The injured worker's diagnostic studies, surgeries and procedure included hernia repair in 2008, right shoulder status post arthroscopy times 2; 2007 and 2012, per injured worker. The injured workers treatments were 15 sessions of1physical therapy, x-rays, MRI on 11/2011 that revealed tendon damage to the right shoulder, in 2006 right shoulder surgery performed, second right should surgery in 04/2012 with no benefit, 2 injections to right shoulder , EMG and nerve conduction studies of the neck, shoulders, elbows, and wrist with unknown results. The medications were Ibuprofen, Tylenol, Naproxen and Tramadol. The treatment plan was for Ketoprofen/Cyclobenzaprine /Lidocaine 10%/13%/5%; 120 gm. The request for authorization form and rationale for the request were not provided within the documentation submitted for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

KETOPROFEN / CYCLOBENZAPRINE / LIDOCAINE 10% / 13% / 5% ; 120gm: 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): 111-113.

Decision rationale: The request for one prescription of topical compounded Ketoprofen/ Cyclobenzaprine/ Lidocaine 10%/13%/5%; 120 gm is non-certified. The California Medical Treatment Utilization Schedule (MTUS) guidelines topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. Any compounded product containing at least one drug (or drug class) that is not recommended is not recommended. The guidelines further state, Ketoprofen is not FDA approved for topical application. There is no information for Cyclobenzaprine used at a topical compound. There is limited, mixed-evidence that does not allow for a recommendation of cyclobenzaprine for chronic use. There are no commercially approved topical formulations of Lidocaine (whether creams, lotions or gels) indicated for neuropathic pain. The requested cream contains at least one drug that is not recommended; therefore, the cream is not supported by guidelines. The requested rub has more than one drug that is not recommended. As such, the above request is not medically necessary.