

Case Number:	CM14-0005197		
Date Assigned:	01/24/2014	Date of Injury:	05/01/2012
Decision Date:	06/23/2014	UR Denial Date:	01/10/2014
Priority:	Standard	Application Received:	01/14/2014

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 Texas. 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 female who is reported to have sustained work related injuries on 05/01/12. She is reported to have sustained injuries as the result of cumulative trauma. The injured worker has been diagnosed with osteoarthritis of the right upper extremity, right rotator cuff tear, and right carpal tunnel syndrome. Treatment has included oral medications, physical therapy, and two shoulder injections. A request was made for Cyclo-Keto-Lido Cream 240 grams, Motin 800 mg #60, and Prilosec 20 mg #30 which was non certified under utilization review on 01/10/14.

IMR ISSUES, DECISIONS AND RATIONALES

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

ONE CYCLO-KETO-LIDO CREAM 240GM: 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 Chronic Pain Medical Treatment Guidelines Topical Analgesics Page(s): 112-113. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chronic Pain, Compounded Medications.

Decision rationale: The request for Cyclo-Keto-Lido Cream 240 grams is not supported as medically necessary. The California Medical Treatment Utilization Schedule, Official Disability Guidelines and US Food and Drug Administration (FDA) do not recommend the use of compounded medications as these medications are noted to be largely experimental in use with few randomized controlled trials to determine efficacy or safety. Further, the FDA requires that all components of a transdermal compounded medication be approved for transdermal use. This compound contains: cyclobenzaprine and Ketoprofen which have not been approved by the FDA for transdermal use. Any compounded product that contains at least one drug (or drug class) that is not recommended and therefore not medically necessary.

60 TABLETS OF MOTRIN 800MG: Overturned

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 Chronic Pain Medical Treatment Guidelines NSAID's Page(s): 67-73.

Decision rationale: The request for Motrin 800mg # 60 is recommended as medically necessary. The submitted records indicate the injured worker has been diagnosed with osteoarthritis for which this medication is clinically indicated. As such medical necessity is established.

30 CAPSULES OF PRILOSEC 20MG: Overturned

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 Chronic Pain Medical Treatment Guidelines NSAID's Page(s): 67-73. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter, Proton Pump Inhibitors

Decision rationale: In accordance with the Chronic Pain Medical Treatment Guidelines, the request for Prilosec 20 mg # 30 is recommended as medically necessary. The submitted clinical records indicate the injured worker has been diagnosed with osteoarthritis and requires non-steroidal anti-inflammatory medications (NSAID) therapy. Per a 10/11/13 consult, the injured worker has been diagnosed with non-steroidal anti-inflammatory medications (NSAID) induced gastritis requiring proton pump inhibitor therapy. As such the medical necessity for this medication has been established.