

Case Number:	CM14-0006628		
Date Assigned:	02/28/2014	Date of Injury:	09/24/2012
Decision Date:	07/28/2014	UR Denial Date:	01/02/2014
Priority:	Standard	Application Received:	01/17/2014

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 32-year-old female who reported an injury on 09/24/2012. The mechanism of injury was not provided. Prior treatments included medication therapy with omeprazole, cyclobenzaprine, Motrin, Cartivisc, and topical creams as of 05/2013. The documentation of 10/11/2013 revealed the injured worker had pain of 9/10 in the neck and low back. The injured worker's diagnoses included neck strain and low back pain. The treatment plan included omeprazole 20 mg, gabapentin/ketoprofen, lidocaine topical, Cartivisc, and cyclobenzaprine.

IMR ISSUES, DECISIONS AND RATIONALES

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

Omeprazole 20 mg #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS Page(s): 69.

Decision rationale: The California MTUS Guidelines recommend PPIs for the treatment of dyspepsia secondary to NSAID therapy. There should be documentation of the efficacy of the requested medication. The duration of use was greater than 5 months. There was a lack of

documented efficacy. The request as submitted failed to indicate the frequency for the requested medication. Given the above, the request for Omeprazole 20 mg #60 is not medically necessary.

Cyclobenzaprine 7.5 mg #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants Page(s): 63.

Decision rationale: The California MTUS Guidelines recommend muscle relaxants as a second line option for the short-term treatment of acute low back pain and their use is recommended for less than 3 weeks. There should be documentation of objective functional improvement. The clinical documentation submitted for review indicated the injured worker had been utilizing the medication for greater than 5 months. There was a lack of documented functional benefit. There was a lack of documentation of exceptional factors to warrant non-adherence to guideline recommendations. The request as submitted failed to indicate the frequency for the requested medication. Given the above, the request for Cyclobenzaprine 7.5 mg #60 is not medically necessary.

Cartivisc 500/200/150 mg #90: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Glucosamine (and Chondroitin Sulfate) Page(s): 50.

Decision rationale: The California MTUS Guidelines recommend glucosamine as a treatment for pain in knee osteoarthritis and moderate arthritis pain. The clinical documentation submitted for review indicated the injured worker had been utilizing the medication for greater than 5 months. There was a lack of documentation of objective functional benefit and an objective decrease in pain. The request as submitted failed to provide the frequency for the requested medication. Given the above, the request for Cartivisc 500/200/150 mg #90 is not medically necessary.

Motrin 800 mg #90: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS Page(s): 67.

Decision rationale: The California MTUS Guidelines recommend NSAIDs for the short-term symptomatic treatment of low back pain. It is generally recommended that the lowest effective dose be used for all NSAIDs for the shortest duration of time consistent with the individual patient treatment goals. There should be documentation of objective functional improvement and an objective decrease in pain. The clinical documentation submitted for review indicated the injured worker had been utilizing the medication for greater than 5 months. There was a lack of documentation of objective functional benefit and an objective decreased in pain. The request as submitted failed to indicate the frequency for the requested medication. Given the above, the request for Motrin 800 mg #90 is not medically necessary.

Gabapentin 6%/Lidocaine Hcl 6.15%/Ketoprofen 20% compounded cream: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Compounded Topical Medications, Topical Capsaicin, Topical Lidocaine, And Menthol.

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

Decision rationale: California MTUS indicate that topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed . Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Regarding the use of Ketoprofen: This agent is not currently FDA approved for a topical application . Gabapentin: Not recommended. There is no peer-reviewed literature to support use. Other anti-epilepsy drugs: There is no evidence for use of any other anti-epilepsy drug as a topical product. The California MTUS guidelines indicate that topical lidocaine (Lidoderm) may be recommended for localized peripheral pain after there has been evidence of a trial of first-line therapy (tri-cyclic or SNRI anti-depressants or an AED such as gabapentin or Lyrica). No other commercially approved topical formulations of lidocaine (whether creams, lotions or gels) are indicated for neuropathic pain. The clinical documentation submitted for review indicated the injured worker had been utilizing the medication for greater than 5 months. There was a lack of documentation of objective functional benefit and an objective decrease in pain. Additionally, there was a lack of documentation of exceptional factors to warrant non-adherence to Guideline recommendations. The request as submitted failed to indicate the frequency and the quantity of medication being requested. Given the above, the request for Gabapentin 6%/Lidocaine Hcl 6.15%/Ketoprofen 20% compounded cream is not medically necessary.

Follow up in 4 weeks: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, Office visits.

Decision rationale: The Official Disability Guidelines indicate the need for a clinical office visit with a health care provider is individualized based upon the review of the patient's concerns, signs and symptoms, clinical stability, and reasonable physician judgment. The request as submitted failed to indicate what type of followup was being requested. Given the above, the request for FOLLOW UP IN 4 WEEKS is not medically necessary. Additionally, there was a lack of documentation indicating the quantity of followup visits being requested.

240MG tube of Capsaicin .0375%, Ketoprofen 20%-Menthol 10% Compounded Cream:
Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Salicylates, Topical Analgesics, Capsaicin, Topical Ketoprofen Page(s): 105, 111, 28, 112.

Decision rationale: The California MTUS indicate that topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Topical Salicylates are recommended Capsaicin is recommended only as an option in patients who have not responded or are intolerant to other treatments. 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. Regarding the use of Ketoprofen: This agent is not currently FDA approved for a topical application. The clinical documentation submitted for review indicated the injured worker had been utilizing topical creams for greater than 5 months. There was a lack of documentation of objective functional benefit and an objective decrease in pain. Additionally, there was a lack of documentation of exceptional factors to warrant non-adherence to Guideline recommendations. The request as submitted failed to indicate the frequency and the quantity of medication being requested. Given the above, the request for 240MG tube of capsaicin .0375%, Ketoprofen 20%-menthol 10% compounded cream is not medically necessary.