

Case Number:	CM14-0010358		
Date Assigned:	02/21/2014	Date of Injury:	07/30/2010
Decision Date:	08/07/2014	UR Denial Date:	01/15/2014
Priority:	Standard	Application Received:	01/28/2014

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 Occupational Medicine and is licensed to practice in California. 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:

This is a 57 year-old male with a 7/30/10 date of injury secondary to constant truck driving. The patient is status post anterior posterior fusion decompression at L5/S1 on 5/1/13. The patient was seen on 1/24/14 with complaints of neck and back pain. Exam findings revealed decreased cervical and lumbar range of motion with decrease in upper extremity strength, and no sensory deficits. Straight leg raise is positive on the right. EHL and peroneus longus strength is 4/5, otherwise lower motor strength is 5/5. Treatment to date include: cervical, lumbar, and left shoulder surgery, medications, PT, cortisone injections. An adverse determination was received on 1/15/14 given MTUS guidelines do not support the use of this medication.

IMR ISSUES, DECISIONS AND RATIONALES

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

Prescription of topical cream (Flurbiprofen 20% gel 120gm and Ketoprofen 20%+ Ketamine 10% gel 120gm): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Capsaicin, Topical Analgesics Page(s): 111-113. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter-Topical Analgesics.

Decision rationale: CA MTUS Chronic Pain Medical Treatment Guidelines state that Ketoprofen, Lidocaine (in creams, lotion or gels), Capsaicin in anything greater than a 0.025% formulation, Baclofen, and other muscle relaxants, and Gabapentin and other antiepilepsy drugs are not recommended for topical applications. ODG states that Ketamine is not approved for topical use. In addition, any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. This topical cream contains Ketamine, Ketoprofen, and Flurbiprofen, all of which are not supported per MTUS and ODG. Therefore, the request for Flurbiprofen 20% gel 120gm and Ketoprofen 20%+ Ketamine 10% gel 120gm is not medically necessary.