

Case Number:	CM14-0010566		
Date Assigned:	02/21/2014	Date of Injury:	05/29/2006
Decision Date:	06/13/2014	UR Denial Date:	12/23/2013
Priority:	Standard	Application Received:	01/27/2014

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 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:

The injured worker is a 57 year old female who reported an injury of unknown mechanism on 05/29/2006. In the clinical note dated 11/20/2013, the injured worker complained of continued neck and back pain following cervical, thoracic, and lumbar fusion surgeries. The injured worker is noted as considering spinal cord stimulation. The physical examination revealed spasm, tenderness, and guarding of the paravertebral musculature of the cervical and lumbar spine with loss of range of motion in both. The treatment plan included refilling prescribed medications as they were providing her pain relief and improved her functional status. The work restrictions consisted of avoidance of lifting, pushing, and pulling more than 20 pounds and avoidance of overhead work and over shoulder work bilaterally. The diagnoses were cervical radiculopathy and shoulder impingement. The request for authorization was not submitted.

IMR ISSUES, DECISIONS AND RATIONALES

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

POS KETOPROFEN POWDER: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics, Page(s): 111-112.

Decision rationale: The California MTUS guidelines state that topical Non-Steroidal Anti-Inflammatory Drugs (NSAID) are recommended for osteoarthritis and tendinitis, in particular, that of the knee and elbow or other joints that are amenable to topical treatment; however, there is little evidence to utilize topical NSAIDs for treatment of osteoarthritis of the spine, hip or shoulder. Ketoprofen is not currently FDA approved for topical application. Ketoprofen has an extremely high incidence of photocontact dermatitis. In the clinical documentation provided for review and the request, the site at which the medication was to be applied was unclear, the quantity or dosage of Ketoprofen to be used. The guidelines do not recommend the usage of Ketoprofen, therefore the request for POS Ketoprofen powder is not medically necessary and appropriate.

LIDOCAINE POWDER: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics, Page(s): 111-112.

Decision rationale: The California MTUS guidelines state that Lidocaine is 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 Anti-Epilepsy Drugs (AEDs) such as Gabapentin or Lyrica). No other commercially approved topical formulations of lidocaine (whether creams, lotions, or gels) are indicated for neuropathic pain. In the clinical documentation provided for review, it is unclear of the area of application, the quantity or dosage of Lidocaine powder to be used. The guidelines also recommend Lidocaine 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). As the guidelines do not recommend Lidocaine for topical use in forms other than Lidoderm, the medication is not indicated. The clinical notes provided lacked documentation of any first-line therapy tri-cyclics or SNRI anti-depressants, therefore, the request for Lidocaine powder is non-medically necessary and appropriate.

BACLOFEN POWDER: Upheld

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

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

Decision rationale: The California MTUS guidelines state that Baclofen is not recommended. There is currently one Phase III study of Baclofen-Amitriptyline-Ketamine gel in cancer patients for treatment of chemotherapy-induced peripheral neuropathy. There is no peer-reviewed literature to support the use of topical baclofen. In the clinical documentation provided for review and the request, the site at which the medication was to be applied was unclear, the

quantity or dosage of Ketoprofen to be used. The guidelines also do not recommend the use of Baclofen, therefore; the request for Baclofen is not medically necessary and appropriate.

PCCA LIDODERM BASE: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics, Page(s): 111-112.

Decision rationale: The California MTUS guidelines state lidoderm for neuropathic pain is 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). Non-dermal patch formulations are generally indicated as local anesthetics and anti-pruritics. Further research is needed to recommend this treatment for chronic neuropathic pain disorders other than post-herpetic neuralgia. In the clinical documentation provided for review and the request, the site at which the medication was to be applied was unclear, the quantity or dosage of Ketoprofen to be used. There was also a lack of documentaton of first-line therapy of tri-cyclic or SNRI anti-depressants or an AED such gabapentin or Lyrica being used. As the guidelines do not recommend Lidocaine for topical use in forms other than Lidoderm, the medication is not indicated. Therefore, the request for PCCA Lidoderm base is not medically necessary and appropriate.