

Case Number:	CM14-0011108		
Date Assigned:	02/21/2014	Date of Injury:	03/27/2008
Decision Date:	08/06/2014	UR Denial Date:	12/26/2013
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:

The patient is a 48-year-old female who has filed a claim for post lumbar fusion surgery associated with an industrial injury date of March 27, 2008. Review of progress notes indicates minimal improvement of back pain symptoms after lumbar decompression and fusion, but with some improvement in the legs. Patient also complains of neck pain radiating between the shoulder and clavicle; right wrist and thumb pain; low back pain radiating to the left buttock; right knee pain radiating to the lower extremity with weakness; and feelings of generalized deconditioning and weakness. Findings include intact motor strength and sensory examination of the lower extremities; and a clean, dry, intact wound. Patient uses a walker. X-rays of the lumbar spine dated April 21, 2014 showed good alignment with progression of fusion. Treatment to date has included opioids, antidepressants, topical analgesics, muscle relaxants, sedatives, lumbar pillow, and low back surgeries in March 2010 and October 2013. Utilization review from December 26, 2013 denied the requests for gel mattress as there is no support for any particular type of mattress in the treatment of chronic pain; Flurbiprofen 20% gel 120gm, Ketoprofen 20% 12gm, Ketamine 10% gel 120gm, and Gabapentin 10%/Cyclobenzaprine 10%/Capsaicin 0.0375% 120gm as these are not supported for topical use.

IMR ISSUES, DECISIONS AND RATIONALES

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

Gel mattress: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG (Online Edition), (http://www.odg-twc.com/odgtwc/low_back.htm).

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, Mattress selection.

Decision rationale: The CA MTUS does not address this topic. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, ODG was used instead. According to ODG, it is not recommended to use firmness as sole criteria for mattress selection. In this case, the patient has a hospital bed, but feels that it is too small and very uncomfortable. However, there is no indication regarding the medical necessity of a certain type of mattress over another. Therefore, the request for gel mattress was not medically necessary and appropriate.

Flurbiprofen 20% gel 120 gm.: 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: As noted on pages 111-113 in the California MTUS Chronic Pain Medical Treatment Guidelines, there is little to no research as for the use of Flurbiprofen in compounded products. In addition, there is no documentation regarding intolerance to or failure of conventional oral pain medications. There is no discussion concerning the need for variance from the guidelines. Therefore, the request for Flurbiprofen 20% gel 120gm was not medically necessary and appropriate.

Ketoprofen 20% 12gm: 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: As noted on page 111-113 of the CA MTUS Chronic Pain Medical Treatment Guidelines, many agents are compounded as monotherapy or in combination for pain control. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Ketoprofen is not currently FDA-approved for topical application. It has an extremely high incidence of photocontact dermatitis. In addition, there is no documentation regarding intolerance to or failure of conventional oral pain medications. There is

no discussion concerning the need for variance from the guidelines. Therefore, the request for Ketoprofen 20% 12gm was not medically necessary and appropriate.

Ketamine 10% gel 120 gm.: 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: As noted on page 111-113 of the CA MTUS Chronic Pain Medical Treatment Guidelines, any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Ketamine is only recommended for treatment of neuropathic pain in refractory cases in which all primary and secondary treatment has been exhausted. There is no documentation regarding failure of all primary and secondary treatment for neuropathic pain in this patient to support this request. Therefore, the request for Ketamine 10% gel 120gm was not medically necessary and appropriate.

Gabapentin 10%/ Cyclobenzaprine 10%/ Capsaicin 0.0375% 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 page 28 and Topical Analgesics Page(s): 111-113.

Decision rationale: According to CA MTUS Chronic Pain Medical Treatment Guidelines pages 111-113, any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Gabapentin is not recommended for use as a topical analgesic. Likewise, cyclobenzaprine has no evidence for use as a topical product. Regarding the Capsaicin component, CA MTUS Chronic Pain Medical Treatment Guidelines on page 28 states that topical Capsaicin is only recommended as an option when there is failure to respond or intolerance to other treatments; with the 0.025% formulation indicated for osteoarthritis. In this case, there is no documentation regarding failure of or intolerance to conventional oral medications. Also, there is no guideline support for topical use of gabapentin, cyclobenzaprine, and capsaicin in a 0.0375% formulation. Therefore, the request for Gabapentin 10%, Cyclobenzaprine 10%, Capsaicin 0.0375% 120gm was not medically necessary and appropriate.