MAXIMUS Federal Services

Case Number:	CM14-0011173		
Date Assigned:	02/21/2014	Date of Injury:	11/13/2010
Decision Date:	06/25/2014	UR Denial Date:	12/27/2013
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 Surgery, 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:

This is a 57 year old claimant who on 11/13/2010 fell backwards onto his left arm. He suffered a left shoulder injury, left elbow fracture (proximal radial and ulna fractures) and left wrist dislocation. He has undergone Open Reduction Internal Fixation (ORIF) of the elbow fracture. Subsequent MRI of the left shoulder revealed a rotator cuff tear such that a shoulder arthroscopy with repair and debridement was performed in June 2011. Hardware from the elbow surgery was removed and there was surgery on the intrinsic muscles of the left hand. These were all performed before December 2011. There has been a bone scan of the left upper extremity to rule CRPS. The bone scan was consistent with arthritis of the left shoulder and left elbow. No acute findings consistent with CRPS were noted. The claimant developed pain about the left shoulder. The treating physician has diagnosed the claimant to have pain in the joints of the shoulder, arm and forearm as well as cervicalgia. The claimant has had electrodiagnostic testing showing only ulnar neuropathy and an Agreed Panel QME exam on 6/4/2013. The claimant continues to see the treating physician and has been prescribed compounded medications as well as Alprazolam, and repeat left Acromioclavicular joint injections. Office notes from 9/16/13 thru 12/6/13 from the treating physician were provided. There was a UR determination on 12/27/13 of the denial of same.

IMR ISSUES, DECISIONS AND RATIONALES

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

LEFT ACROMIOCLAVICULAR JOINT INJECTION: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: ACOEM, INJECTIONS, 561-563

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 561-563.

Decision rationale: The claimant has had previous shoulder injections and the office note of the treating physician of 12/6/13 states that the previous injection was not of any significant benefit. Therefore repeat injection would not be medically necessary or reasonable. This is not recommended for certification.

ALPRAZOLAM 0.5 MG, T TAB Q12 HOURS #30: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: CHRONIC PAIN MEDICAL TREATMENT GUIDELINES, BENZODIAZEPINES, 24

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines Page(s): 24.

Decision rationale: Alprazolam has been prescribed as a twice daily medication. CAMTUS states that benzodiazepines are not recommended for long-term use as its efficacy remains unproven and may lead to dependence. Generally its use is limited to 4 weeks by most guidelines. Anxiety is best addressed by Cognitive Behavior Therapy and or antidepressants. This is not recommended for certification.

TOPIRAMATE 100 MG EVERY 12 HOURS FOR NERVE PAIN # 60: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: CHRONIC PAIN MEDICAL TREATMENT GUIDELINES, OTHER ANTIEPILEPTIC DRUGS, 21

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Other Antiepileptic Drugs Page(s): 21.

Decision rationale: This drug is the first line antiepileptic/membrane stabilizing drug for neuropath pain. Topimirate has been shown to have variable efficacy with regards to neuropathic pain. CAMTUS states that Topamax be considered "when other anticonvusants drugs have failed." There is no documentation that other antiepileptic drugs have been used and failed. This is not recommended for certification.

KETOPR./KETAM./LIDOC./GABAP. CREAM TSP. TO AFFECTED AREA TID(THREE TIMES A DAY): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: CHRONIC PAIN MEDICAL TREATMENT GUIDELINES, TOPICAL ANALGESICS, 111-112

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

Decision rationale: This is a compounded topical analgesic that includes Ketoprofen, Ketamine, Lidocaine and Gabapentin. Ketoprofen is not FDA approved for topical application. There have been high number of reports of photocontact dermatitis. Topical application may result is blood concentration equivalent to oral forms and systemic side effects are comparable to oral forms. Therefore Ketoprofen is not recommended for certification. Ketamine is an anesthetic agent. Its use in treatment for neuropathic pain is under study for CRPS only. It is recommended for treatment as a last ditch effort to control neuropathic pain for "cases in which all primary and secondary treatment has been exhausted." The documentation does not reflect such. Therefore Ketamine is not recommended for certification. Lidocaine is recommended as a treatment for neuropathic pain. However its formulation with other medication that are not recommended (ketoprofen, ketamine) is problematic. ODG holds that compounded medications that include a medication not recommended is not medically necessary. Therefore Lidocaine is not recommended for certification in this compounded medication. Gabapentin is not recommeded by either CAMTUS or ODG for topical use. There is no medical literature in Randomized controlled trials to support its topical application. This is not recommended for certification.

CYCLOGABA CREAM 10%/10%, APPLIED TO SENSITIVE AREA DAILY AND PRN(AS NEEDED) SPASM: 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 Topical Analgesics Page(s): 111-112. Decision based on Non-MTUS Citation Official Disability Guidelines ODG Pain, Topical analgesics, Cyclobenzaprine

Decision rationale: This CycloGaba topical cream is combination of Cyclobenzaprine and gabapentin for topical application. Cyclobenzaprine is a muscle relaxant which when taken orally is recommended for short term use only and its mode of action is thought be centrally acting. Its topical application is not FDA approved. There is no documentation of any oral use of cyclobenzaprine. Gabapentin is not supported by CAMTUS or ODG as a topical medication. Therefore CycloGaba is not recommended for certification.