MAXIMUS Federal Services

Case Number:	CM14-0012188		
Date Assigned:	02/21/2014	Date of Injury:	05/18/2010
Decision Date:	07/15/2014	UR Denial Date:	12/26/2013
Priority:	Standard	Application Received:	01/30/2014

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 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 44 year old male injured on 05/18/10 due to undisclosed mechanism of injury. Current diagnoses included mild left L5 radiculopathy with acute denervation and L4-5 left extruded herniated nucleus pulposus displacing intrathecal nerve root. Clinical documentation dated 11/12/13 indicated the injured worker presented for reevaluation of his back and leg pain. The injured worker reported doing extremely well without any significant recurrences of low back pain. The injured worker was tolerating normal duty at work and had been compliant with home exercise program. Physical examination revealed normal range of motion of the lumbar spine, positive straight leg raise on the left, 2+ deep tendon reflexes to bilateral lower extremities, 5/5 motor strength bilaterally, and sensory examination within normal limits. Treatment plan included continuation with home exercise program and return for routine follow up. List of current medications was not provided for review. The initial request for Ketoprofen/lidocaine/capsaicin/tramadol 15%/1%/0.012%/5% #60 and flurbiprofen/ Cyclobenzaprine/capsaicin/lidocaine 10%/2%/0.0125% #120 was initially non- certified on 12/26/13.

IMR ISSUES, DECISIONS AND RATIONALES

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

KETOP/ LIDOC/ CAP/ TRAM 15%/ 1%/ 0.012%/ 5% #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 9792.20, TOPICAL ANALGESICS Page(s): 111-113.

Decision rationale: As noted on page 111 of the MTUS Chronic Pain Guidelines, the safety and efficacy of compounded medications has not been established through rigorous clinical trials. Topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. There is no indication in the documentation that these types of medications have been trialed and/or failed. Further, the MTUS Chronic Pain Guidelines require that all components of a compounded topical medication be approved for transdermal use. This compound contains multiple components which have not been approved for transdermal use. In addition, there is no evidence within the medical records submitted that substantiates the necessity of a transdermal versus oral route of administration. Therefore, the request is not medically necessary and appropriate.

FLUR/CYCLO/ CAPS/LID 10%/2%/0.0125% #120: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 9792.20, TOPICAL ANALGESICS Page(s): 111-113.

Decision rationale: As noted on page 111 of the MTUS Chronic Pain Guidelines, the safety and efficacy of compounded medications has not been established through rigorous clinical trials. Topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. There is no indication in the documentation that these types of medications have been trialed and/or failed. Further, the MTUS Chronic Pain Guidelines require that all components of a compounded topical medication be approved for transdermal use. This compound contains multiple components which have not been approved for transdermal use. In addition, there is no evidence within the medical records submitted that substantiates the necessity of a transdermal versus oral route of administration. Therefore, the request is not medically necessary and appropriate.