

Case Number:	CM14-0017278		
Date Assigned:	04/14/2014	Date of Injury:	03/04/2013
Decision Date:	08/29/2014	UR Denial Date:	02/07/2014
Priority:	Standard	Application Received:	02/11/2014

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 Family Practice and is licensed to practice in Texas and Georgia. 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 28-year-old female who reported an injury on 03/04/2013. The mechanism of injury involved repetitive activity. Current diagnoses include moderate degenerative thinning of the radial aspect of the triangular fibrocartilage, ganglion cyst, and no evidence of avascular necrosis of the lunate or other significant osseous abnormality. The latest clinical documentation submitted for this review is an Agreed Medical Evaluation on 02/10/2014. It is noted that the injured worker has been previously treated with splinting and physical therapy. The injured worker reported throbbing pain in the bilateral wrists. Physical examination on that date revealed limited range of motion of the bilateral wrists, normal muscle strength in the forearms and elbows, limited grip strength bilaterally, 2+ deep tendon reflexes, positive Tinel's and Phalen's testing and positive carpal tunnel compression testing. X-rays obtained in the office on that date indicated normal findings of the bilateral wrists and hands. It is noted that future medical treatment included aspiration of the ganglion cyst and possible surgical excision with decompression of the carpal tunnel.

IMR ISSUES, DECISIONS AND RATIONALES

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

KETOPROFEN 20%/ KETAMINE 10% GEL 120GMS: Upheld

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

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

Decision rationale: California MTUS Guidelines state topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. Any compounded product that contains at least 1 drug that is not recommended is not recommended as a whole. The only FDA approved topical NSAID is diclofenac. Therefore, the current request cannot be determined as medically appropriate. There is also no frequency listed in the current request. As such, the request for Ketoprofen20%/ Ketamine 10% Gel 120GMS is not medically necessary.

FLURBIPROFEN20% GEL 120GMS: Upheld

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

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

Decision rationale: California MTUS Guidelines state topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. Any compounded product that contains at least 1 drug that is not recommended is not recommended as a whole. The only FDA approved topical NSAID is diclofenac. Therefore, the current request cannot be determined as medically appropriate. There is also no frequency listed in the current request. As such, the request for Flurbiprofen20% Gel 120GMS is not medically necessary.

GABAPENTIN 10%/ CYCLOBENZAPRINE 10%/ CAPSAICIN 0.0375%, 120GMS:
Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 11-113.

Decision rationale: California MTUS Guidelines state topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. Any compounded product that is not recommended is not recommended as a whole. Gabapentin is not recommended as there is no peer reviewed literature to support its use as a topical product. Muscle relaxants are also not recommended. There is also no frequency listed in the current request. As such, the request for Gabapentin 10%/ Cyclobenzaprine 10%/ Capsaicin 0.0375%, 120gms is not medically necessary.