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| Case Number: | CM14-0159193 | | |
| Date Assigned: | 10/02/2014 | Date of Injury: | 07/24/2009 |
| Decision Date: | 10/28/2014 | UR Denial Date: | 09/10/2014 |
| Priority: | Standard | Application Received: | 09/29/2014 |

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 Internal Medicine, has a subspecialty in Rheumatology and is licensed to practice in Maryland. 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 52 year old female with date of injury 7/21/2009. The mechanism of injury is not stated in the available medical records. The patient has complained of lower back pain with radiation of pain to the lower extremities since the date of injury. She has been treated with acupuncture, physical therapy and medications. There are no radiographic data included for review. Objective: decreased and painful range of motion of the lumbosacral spine, positive straight leg raise test bilaterally, decreased light touch sensation in the bilateral lower legs. Diagnoses: lumbosacral disc injury, lower back pain, lumbosacral radiculopathy. Treatment plan and request: Gabapentin /Ketoprofen/ Lidocaine 7/10/5% in UL, 30gm, Ketoprofen 20%, Gabapentin/Ketoprofen/Lidocaine 7/10/5%, Ketoprofen 20%.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retrospective (DOS 04/07/14) Gabapentin/Ketoprofen/Lidocaine 7/10/5% in UL, 30gm QTY:2.00: 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.

Decision rationale: This 52 year old female has complained of lower back pain with radiation of pain to the lower extremities since date of injury 7/21/2009. She has been treated with acupuncture, physical therapy and medications. The current request is for Gabapentin/Ketoprofen/Lidocaine 7/10/5%. Per the MTUS guidelines cited above, the use of topical analgesics in the treatment of chronic pain is largely experimental, and when used, is primarily recommended for the treatment of neuropathic pain when trials of first line treatments such as anticonvulsants and antidepressants have failed. There is no such documentation in the available medical records. On the basis of the MTUS guidelines cited above, Gabapentin/Ketoprofen/Lidocaine 7/10/5% is not indicated as medically necessary.

Retrospective (DOS 04/07/14) Ketoprofen 20% in UL, 30gm QTY:2.00: 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.

Decision rationale: This 52 year old female has complained of lower back pain with radiation of pain to the lower extremities since date of injury 7/21/2009. She has been treated with acupuncture, physical therapy and medications. The current request is for Ketoprofen 20%. Per the MTUS guidelines cited above, the use of topical analgesics in the treatment of chronic pain is largely experimental, and when used, is primarily recommended for the treatment of neuropathic pain when trials of first line treatments such as anticonvulsants and antidepressants have failed. There is no such documentation in the available medical records. On the basis of the MTUS guidelines cited above, Ketoprofen 20% is not indicated as medically necessary.

Retrospective (DOS 04/07/14) Gabapentin/Ketoprofen/Lidocaine 7/10/5% in UL, 120gm QTY:2.00: 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.

Decision rationale: This 52 year old female has complained of lower back pain with radiation of pain to the lower extremities since date of injury 7/21/2009. She has been treated with acupuncture, physical therapy and medications. The current request is for Gabapentin/Ketoprofen/Lidocaine 7/10/5%. Per the MTUS guidelines cited above, Per the MTUS guidelines cited above, the use of topical analgesics in the treatment of chronic pain is largely experimental, and when used, is primarily recommended for the treatment of neuropathic pain when trials of first line treatments such as anticonvulsants and antidepressants have failed. There is no such documentation in the available medical records. On the basis of the MTUS guidelines cited above, Gabapentin/ Ketoprofen/Lidocaine 7/10/5% is not indicated as medically necessary.

Retrospective (DOS 04/07/14) Ketoprofen 20% in UL, 120gm QTY:2.00: 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.

Decision rationale: This 52 year old female has complained of lower back pain with radiation of pain to the lower extremities since date of injury 7/21/2009. She has been treated with acupuncture, physical therapy and medications. The current request is for Ketoprofen 20%. Per the MTUS guidelines cited above, the use of topical analgesics in the treatment of chronic pain is largely experimental, and when used, is primarily recommended for the treatment of neuropathic pain when trials of first line treatments such as anticonvulsants and antidepressants have failed. There is no such documentation in the available medical records. On the basis of the MTUS guidelines cited above, Ketoprofen 20% is not indicated as medically necessary.