MAXIMUS Federal Services

Case Number:	CM14-0163109		
Date Assigned:	10/08/2014	Date of Injury:	01/07/2014
Decision Date:	11/10/2014	UR Denial Date:	09/24/2014
Priority:	Standard	Application Received:	10/03/2014

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:

Patient is a 51 year-old female with date of injury 01/07/2014. The medical document associated with the request for authorization, a primary treating physician's progress report, dated 09/10/2014, lists subjective complaints as pain in the right shoulder. Patient is status post right shoulder arthroscopic surgery on 09/02/2014. Objective findings: Examination of the right shoulder revealed anterior tenderness with weakness and limited range of motion. Patient was weak in internal and external rotation. Diagnosis: 1. Status post right shoulder arthroscopy 2. Anterior instability of the right shoulder. The medical records supplied for review document that the patient had not been prescribed any of the following medications before the date of the request for authorization o 09/10/2014. Medications:1.Orphenadrine/caffeine 50/10mg, #602.Gabapentin/pyridoxine 250/10mg, #120 SIG: two times daily3.Keratex gel 28%/16%, 4oz4.Flurboprofen/cyclo/menth cream5.Diclofenac/lidocaine 3%/5% 180gramsSIG not listed in records for some of the above medications.

IMR ISSUES, DECISIONS AND RATIONALES

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

Orphenadrine/ Caffeine 50/10mg Quantity Requested: 60.00 denied: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): Page 63, 65.

Decision rationale: Orphenadrine is an anticholinergic drug of the ethanolamine antihistamine class with prominent central nervous system (CNS) and peripheral actions used to treat painful muscle spasms and other similar conditions, as well as the treatment of some aspects of Parkinson's disease. The MTUS states that muscle relaxants are recommended with caution only on a short-term basis. The patient has been taking orphenadrine for longer than 2-3 weeks, which is recommended by the MTUS. Orphenadrine/ caffeine 50/10mg quantity requested: 60.00 is not medically necessary

Gabapentin/ Pyridoxine 250/10mg Quantity Requested: 120.00: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official medical fee schedule.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain (Chronic), Vitamin B

Decision rationale: The requested medication is a compounded formulation of gabapentin and vitamin B6. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. The Official Disability Guidelines state that vitamin B is not recommended. Vitamin B is frequently used for treating peripheral neuropathy but its efficacy is not clear. A recent meta-analysis concluded that there are only limited data in randomized trials testing the efficacy of vitamin B for treating peripheral neuropathy and the evidence is insufficient to determine whether vitamin B is beneficial or harmful. Gabapentin/ Pyridoxine 250/10mg Quantity Requested: 120.00 is not medically necessary.

Keratex Gel 28% 16% #4 Oz Quantity Requested: 1.00: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation drugs.com keratex gel.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Guidelines 9792.23 Page(s): 3.

Decision rationale: For all conditions or injuries not addressed in the MTUS, the authorized treatment and diagnostic services in the initial management and subsequent treatment for presenting complaints shall be in accordance with other scientifically and evidence-based medical treatment guidelines that are nationally recognized by the medical community pursuant to section 9792.25(b). There are no peer-reviewed guidelines for treatment with a veterinary medication use to treat a horse's hooves. Keratex Gel 28% 16% #4 Oz Quantity Requested: 1.00 is not medically necessary.

Flubiprofen/ Cyclo Menth Cream Quantity Requested: 1.00: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 9792.20 - 9792.26, Page(s): 111-113.

Decision rationale: According to the MTUS, there is little to no research to support the use of many of these Compounded Topical Analgesics. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. This compounded medication contained cyclobenzaprine, a muscle relaxant. There is no evidence for use of any muscle relaxant as a topical product. Flubiprofen/cyclo menth cream quantity requested: 1.00 is not medically necessary.

Diclofenac/Lidocaine 3%/5% 180 Gm Quantity Requested 1.00: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

Decision rationale: According to the MTUS, there is little to no research to support the use of many of these Compounded Topical Analgesics. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. The efficacy in clinical trials for non-steroidal anti-inflammatory agents (NSAIDs) has been inconsistent and most studies are small and of short duration. Topical NSAIDs have been shown in meta-analysis to be superior to placebo during the first 2 weeks of treatment for osteoarthritis, but either not afterward, or with a diminishing effect over another 2-week period. Diclofenac is not recommended by the MTUS; therefore, Diclofenac/Lidocaine 3%/5% 180 Gm Quantity Requested 1.00 is not medically necessary.