

Case Number:	CM14-0023041		
Date Assigned:	05/14/2014	Date of Injury:	10/04/2012
Decision Date:	07/10/2014	UR Denial Date:	02/12/2014
Priority:	Standard	Application Received:	02/24/2014

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 Orthopedic Surgery, has a subspecialty in Orthopedic Sports Medicine 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 40 year old female injured on 10/04/12 due to an undisclosed mechanism of injury. Current diagnoses include bilateral shoulder/bilateral elbow/thoracic/lumbar musculoskeletal sprain/strain/tendinitis, bilateral wrist extensor tendinitis, and fibromyalgia. The clinical note dated 01/27/14 indicates the injured worker presented complaining of frequent neck pain rated at 9/10 with radiation to bilateral upper extremities with associated numbness and tingling. The injured worker also complained of low back pain rated at 9/10 with frequent bilateral shoulder pain rated at 9/10. In addition, the injured worker complained of bilateral elbow pain, bilateral wrist pain and hand pain, both rated at 9/10. The documentation indicated the injured worker has taken Tylenol #3 which does not provide relief. Physical examination revealed paraspinal spasm and tenderness of the lumbar spine, positive sciatic notch tenderness on the right, straight leg raise positive on the right with radiating pain on the posterior aspect of the knee, motor strength testing reveals weakness at 4/5 in the lower extremities, sensation intact, and deep tendon reflexes at the knee and ankle are 1+. The initial request for Tylenol #3 #60 1 tablet every 4-6 hours as needed for pain, Flurbiprofen 20% gel 120 grams applied to the affected area 2-3 times daily as directed by physician, and Ketoprofen 20%/Ketamine 10% gel 120 grams applied to affected areas 2-3 times daily as directed by physician was initially non-certified on 02/12/14.

IMR ISSUES, DECISIONS AND RATIONALES

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

TYLENOL #3 #60 1 TABLET EVERY 4-6 HOURS AS NEED FOR PAIN: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 9792.20, Opioids, criteria for use Page(s): 77.

Decision rationale: As noted on page 77 of the Chronic Pain Medical Treatment Guidelines, patients must demonstrate functional improvement in addition to appropriate documentation of ongoing pain relief to warrant the continued use of narcotic medications. There is no clear documentation regarding the functional benefits or any substantial functional improvement obtained with the continued use of narcotic medications. The documentation indicates the patient reported the use of Tylenol #3 was not beneficial for pain management purposes. As the clinical documentation provided for review does not support an appropriate evaluation for the continued use of narcotics as well as establish the efficacy of narcotics, the medical necessity of Tylenol #3 #60 1 tablet every 4-6 hours as need for pain cannot be established at this time.

FLURBIPROFEN 20% GEL 120 GRAMS - APPLY TO AFFECTED AREA 2-3 TIMES DAILY AS DIRECTED BY PHYSICIAN: 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.

Decision rationale: As noted on page 111 of the Chronic Pain Medical Treatment 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, CAMTUS, Food and Drug Administration, and Official Disability Guidelines require that all components of a compounded topical medication be approved for transdermal use. Flurbiprofen has 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 Flurbiprofen 20% gel 120 grams - apply to affected area 2-3 times daily as directed by physician cannot be recommended as medically necessary as it does not meet established and accepted medical guidelines.

KETOPROFEN 20%/KETAMIN 10% GEL 120 GRAMS - APPLY TO AFFECTED AREAS 2-3 TIMES DAILY AS DIRECTED BY PHYSICIAN: 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.

Decision rationale: As noted on page 111 of the Chronic Pain Medical Treatment 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, CAMTUS, Food and Drug Administration, and Official Disability Guidelines require that all components of a compounded topical medication be approved for transdermal use. Ketoprofen and Ketamine have not been approved for transdermal use. Therefore Ketoprofen 20%/Ketamine 10% Gel 120 grams - apply to affected areas 2-3 times daily as directed by physician cannot be recommended as medically necessary as it does not meet established and accepted medical guidelines.