

Case Number:	CM14-0023420		
Date Assigned:	06/11/2014	Date of Injury:	12/27/2012
Decision Date:	07/21/2014	UR Denial Date:	01/29/2014
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 Physical Medicine & Rehabilitation, and is licensed to practice in Illinois. 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 59-year-old female who reported an injury on 12/27/2012. The mechanism of injury was not provided. The injured worker's treatment history included physical therapy and mediations. The injured worker was evaluated on 01/14/2014. The injured worker complained of intermittent aching pain of the hands and wrists rated at 6-7/10 on the right and 6-7/10 on the left. It was noted that the injured workers' pain radiated into the right upper extremity. She also complained of popping of the left thumb and weakness to wrists. Physical findings included a positive Finklestein's test of the right hand. The diagnoses were bilateral wrist degenerative changes with mild carpal with cyst, left second and fourth compartment tenosynovitis, right carpal tunnel syndrome, right first compartment tenosynovitis and right index proximal interphalangeal joint volar plate injury. The injured worker's treatment plan was to continue her physical therapy for bilateral upper extremities with deep tissue massage twice a week for four weeks and to continue medications to include medrox patches, flurbiprofen cream, and gabapentin/cyclobenzaprine/capsasin cream. A justification for the request was not provided.

IMR ISSUES, DECISIONS AND RATIONALES

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

MEDROX PATCHES #30: Upheld

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

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

Decision rationale: The requested Medrox patches are not medically necessary or appropriate. Medrox patches contain methyl salicylate 5%, menthol 5% and capsaicin 0.0375%. The California Medical Treatment Utilization Schedule (MTUS) does support the use of methyl salicylate and menthol for osteoarthritic pain. However, the clinical documentation does not indicate that the patient's pain is related to degenerative joint changes. The MTUS recommends that any compounded product that contains at least one drug that is not recommended is not recommended. The guidelines recommend that Capsaicin is an option in patients who have not responded or are intolerant to other treatments. The clinical documentation does not support that the patient has failed to respond to first line medications to include anti-convulsants and anti-depressants. Also, there have been no studies of a 0.0375% formulation of capsaicin and there is no current indication that this increase over 0.025% formulation would provide any further efficacy. In addition, the request does not include a dose, frequency, or body part. In the absence of this information, the appropriateness of the request itself cannot be determined. As such, the above request is not medically necessary or appropriate.

FLURBIPROFEN 20% GEL 120GM: Upheld

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

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

Decision rationale: The request for Flurbiprofen 20% gel 120gm is not medically necessary or appropriate. The CA MTUS recommends the topical use of non-steroidal anti-inflammatory drugs be reserved for injured workers who are intolerant of oral formulations, or when oral formulations are contraindicated. The clinical documentation does not provided any indications that the injured worker has failed a trial of oral non-steroidal anti-inflammatory medications. Additionally, treatment of this type of medication should be limited to four weeks. The request does not include a frequency or duration of treatment; therefore, the appropriateness of on-going use of this medication cannot be determined. As such, the request for Flurbiprofen 20% gel 120gm is not medically necessary or appropriate.

GABAPENTIN 10%/CYCLOBENZAPRINE 10%/CAPSAICIN 0.0375% 120GM: Upheld

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

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

Decision rationale: The request for Gabapentin 10%/cyclobenzaprine 10%/capsaicin 0.0375% 120gm is not medically necessary or appropriate. The CA MTUS guidelines recommend that any compounded product that contains at least one drug that is not recommended is not recommended. The MTUS recommends that capsaicin is recommended only as an option in patients who have not responded or are intolerant to other treatments. The clinical documentation does not indicate that the injured worker has failed to respond to first line medications such as anti-depressants and anti-convulsants. Also, there have been no studies of a 0.0375% formulation of capsaicin and there is no current indication that this increase over 0.025% formulation would provide any further efficacy. There was no justification provided that would support the need for a higher dose of capsaicin. The guidelines do not recommend the topical use of gabapentin or cyclobenzaprine due to a lack of scientific evidence to support the efficacy and safety of the medications in a topical formulation. Furthermore, the request as it is submitted fails to identify a body part for treatment or a frequency of treatment. In the absence of this information, the appropriateness of the request itself cannot be determined. As such, the request for Gabapentin 10%/cyclobenzaprine 10%/capsaicin 0.0375% 120gm is not medically necessary or appropriate.