

Case Number:	CM14-0024196		
Date Assigned:	05/12/2014	Date of Injury:	03/10/2009
Decision Date:	07/10/2014	UR Denial Date:	02/24/2014
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 and Rehabilitation 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:

The patient is a 56 year-old patient sustained an injury on 3/10/09 while employed by [REDACTED]. Request under consideration include retrospective request for Topical Compounds Cyclobenzaprine Ketoprofen 10/3% VC 120 Gm Cream and Retrospective request for and Capsaicin Menthol Camphor (Cap 0.037% Ment 10% Camp 2% Cream) for date of service of 9/7/10. The patient has not worked since 3/10/09 date of injury. Conservative care has included medications, therapy, transfer of care to various providers and specialties, and extended time off. Report of 7/14/10 for retrospective medications with date of service of 9/7/10 noted patient with persistent multifocal neck, shoulder, elbow, wrist, and low back pain with depression, insomnia, anxiety, headaches, and sleep disturbance. Orthopedic report of 8/19/13 noted patient with continued right shoulder pain with exam showing well-healed incision for previous shoulder surgery on right; positive impingement and Hawkins and elevation of right upper extremity against gravity of 95 degrees. Medications list Medrox patch, Prilosec, Anaprox, and Elavil. Diagnosis was Olecranon Bursitis with option of physical therapy, acupuncture, and steroid injection of right subacromial space. There is an operative report of 2/7/14 for right shoulder arthroscopy with synovectomy, chondroplasty and SAD.

IMR ISSUES, DECISIONS AND RATIONALES

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

CYCLOBENZAPRINE KETOPROFEN 10/3% VC 120 GM CREAM (CYCLO/KETO) 10/3% RETRO: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111-112, 122.

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

Decision rationale: According to the MTUS Chronic Pain Medical Treatment Guidelines, the efficacy in clinical trials for topical analgesic treatment modality has been inconsistent and most studies are small and of short duration. These medications may be useful for chronic musculoskeletal pain, but there are no long-term studies of their effectiveness or safety. There is little evidence to utilize topical analgesic compound over oral NSAIDs or other pain relievers for a patient with spinal and multiple joint pain without contraindication in taking oral medications as another oral NSAID Anaprox is already prescribed concurrently. Submitted reports have not adequately demonstrated the indication or medical need for this topical analgesic for this chronic injury of 2009. There is no documentation of functional improvement from treatment already rendered. The retrospective request for Cyclobenzaprine Ketoprofen 10/3% VC 120 Gm Cream is not medically necessary and appropriate.

RETROSPECTIVE REQUEST FOR CAPSAICIN MENTHOL CAMPHOR (CAP 0.37% MENT 10% CAMP 2% CREAM): Upheld

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

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

Decision rationale: According to the MTUS Chronic Pain Medical Treatment Guidelines, the efficacy in clinical trials for topical analgesic treatment modality has been inconsistent and most studies are small and of short duration. These medications may be useful for chronic musculoskeletal pain, but there are no long-term studies of their effectiveness or safety. There is little evidence to utilize topical analgesic Capsaicin gel over oral NSAIDs or other pain relievers for a patient without contraindication in taking oral medications. Submitted reports have not adequately demonstrated the indication or medical need for this topical analgesic. In addition, although guidelines recommend Capsicum Creams for chronic low back pain or other chronic persistent pain, it is for short-term treatment of acute exacerbations of chronic low back pain with indications for temporary flare ups of chronic low back pain or other chronic persistent pain. Duration of use for patients with chronic pain is limited to an acute flare-up period, generally lasting no more than 2 weeks. The patient has chronic persistent pain without report of flare-ups. Capsaicin cream/gel is recommended only as an option in patients who have not responded or are intolerant to other treatments. There have been no studies of a 0.0375% formulation of capsaicin and there is no current indication that this increase over a 0.025% formulation would provide any further efficacy. The retrospective request for Capsaicin Menthol Camphor (Cap 0.037% Ment 10% Camp 2% Cream) is not medically necessary and appropriate.

