MAXIMUS Federal Services

Case Number:	CM14-0031710		
Date Assigned:	06/20/2014	Date of Injury:	12/27/2008
Decision Date:	08/14/2014	UR Denial Date:	03/10/2014
Priority:	Standard	Application Received:	03/12/2014

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, has a subspecialty in Pain Medicine and is licensed to practice in Texas and Oklahoma. 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 54-year-old male who reported an injury on 12/27/2008. The mechanism of injury was reported as a fall. The diagnoses included cervical and lumbosacral radiculopathy. Prior therapies included physical therapy and injections. Per the 01/13/2014 follow-up report, the injured worker reported pain and difficulty with his activities of daily living. The provider noted the injured worker was using his medications to control his pain and that medications would be refilled at the lowest dosage. Per the 02/24/2014 follow-up report, the injured worker reported chronic pain in his cervical and lumbar spine and right shoulder. Objective findings included spasm and tenderness in the paravertebral muscles of the cervical and lumbar spine with decreased range of motion on flexion and extension. The provider refilled the patient's medications as they caused no side effects and helped to maintain functional capacity. The Request For Authorization form for therapeutic cream was not present in the medical record.

IMR ISSUES, DECISIONS AND RATIONALES

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

Therapeutic Cream (Lidocaine powder, Gabapentin powder and Ketoprofen micronised powder in a Pendrem Base).Qty 1: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-118.

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

Decision rationale: The request for therapeutic cream (lidocaine powder, gabapentin powder and ketoprofen micronised powder in a pendrem base) quantity 1 is not medically necessary. The California MTUS Guidelines state topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. Any compounded product that contains at least 1 drug that is not recommended is not recommended. The only commercially approved topical formulation of lidocaine is lidoderm. Topical gabapentin is not recommended as there is no peer reviewed literature to support use. Ketoprofen is not currently FDA approved for a topical application. The requested cream contains at least 1 drug that is not recommended for topical application. Based on this information, the request is not supported. In addition, the submitted request does not specify the site of application. As such, the request is not medically necessary.