

Case Number:	CM14-0043688		
Date Assigned:	07/02/2014	Date of Injury:	04/01/1996
Decision Date:	08/21/2014	UR Denial Date:	03/10/2014
Priority:	Standard	Application Received:	04/10/2014

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 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 a 51-year-old female who reported an injury on 04/18/1996. The mechanism of injury was not provided. On 02/13/2014, the injured worker presented with right shoulder pain. Current medications include methotrexate, folic acid, Vitamin D, Oscal, Relafen, Claritin, Omega 3, Ibuprofen, Lipitor and Prilosec. Examination of the bilateral shoulders noted decrease internal rotation bilaterally and mild tenderness upon palpation over the glenohumeral joints, more pronounced on the right than the left. Diagnoses were rheumatoid arthritis, history of repetitive strain injury/overuse syndrome, bilateral carpal tunnel syndrome, history of bilateral de Quervain's stenosing tenosynovitis, bilateral arthroscopic surgery involving the knees and obesity. Prior therapy included medications and physical therapy. The provider recommended compound topical cream and physical therapy. The provider's rationale was not provided. The Request For Authorization form was not included in the medical documents for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Generic S5000 Neurogenic Cream (Ketamine 10%, Baclofen 2%, Cyclobenzaprine 2%, Flurbiprofen 10%, Gabapentin 6%, Lidocaine 5%. 240gm, with one refill): 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.

Decision rationale: The request for a generic S500 neurogenic cream Ketamine, Baclofen, cyclobenzaprine, flurbiprofen, gabapentin, lidocaine 240gm with 1 refill is non-certified. The California MTUS Guidelines state that transdermal compounds are largely experimental in use with few randomized controlled trials to determine efficacy or safety. Topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Any compounded product that contains at least 1 drug or drug class that is not recommended is not recommended. The guidelines note muscle relaxants are not recommended for topical application. The guidelines note gabapentin is not recommended for topical application. Topical NSAIDS are recommended for osteoarthritis and tendonitis in particular that of the knee or elbow or other joints amenable to topical treatments. Recommendations are made for a 4 to 12 week period. There is little evidence to utilize topical NSAIDS to treat osteoarthritis of the spine hip or shoulder. The guidelines do not recommend the use of muscle relaxants or gabapentin for topical application, the medication would not be indicated. It was also unclear if the injured worker had a diagnosis which would be concurrent with the guideline recommendation of topical NSAIDS. Additionally, the provider's request did not indicate the dose or frequency of the cream in the request as submitted. As such, the request is non-certified.

Physical Therapy 3 times a week for 6weeks: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98.

Decision rationale: The request for physical therapy 3 times a week for 6 weeks is non-certified. The California MTUS Guidelines state that active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion and can alleviate discomfort. Active therapy requires an internal effort by the individuals who complete a specific exercise or task. Injured workers are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. There was a lack of documentation indicating the injured worker's prior request of physical therapy as well as the efficacy of the prior therapy. The guidelines recommend 10 visits of physical therapy for up to 4 weeks. The amount of physical therapy visits that have already been completed was not provided. Additionally, injured workers are instructed and expected to continue active therapies at home, there is no significant barrier to transitioning the injured worker to an independent home exercise program. As such, the request is non-certified.