

Case Number:	CM14-0045097		
Date Assigned:	07/02/2014	Date of Injury:	05/15/2012
Decision Date:	08/28/2014	UR Denial Date:	03/14/2014
Priority:	Standard	Application Received:	04/14/2014

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 injured worker is a 43-year-old female who reported an injury on 05/15/2012. The mechanism of injury was not provided within the medical records. Diagnostic studies included an x-ray on the date of injury, an EMG and NCV of the lower extremities performed on 12/19/2013, and an MRI of the lumbar spine performed on 12/01/2013. The injured worker was diagnosed with insomnia, diabetes, sprain or strain to the right ankle and foot, anxiety and depression, low back pain, ankle pain, sciatica, neck pain, and brachial neuritis or radiculitis not otherwise specified. Prior treatments included chiropractic care, a TENS unit, acupuncture, heat pads, and pain management. The clinical note dated 12/19/2013 noted the injured worker reported pain to the bilateral wrists and the shoulders with numbness and tingling in the fingers bilaterally, and weakness to the bilateral upper extremities. The injured worker stated she had pain rated 8/10 which was constant. The injured worker further reported ongoing headaches, dizziness, imbalance, bilateral lower extremity joint stiffness and swelling and tingling. The injured worker's medication regimen included naproxen, topoprophan, and ketocap ultracream. The physician's treatment plan included recommendations for continuation of conservative care with physical therapy, chiropractic care, TENS unit, medications and cream. The provider is requesting topoprophan and ketocap ultracream. However, there was no rationale for the continuation of this medication and cream. The request for authorization form was not submitted for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Toprophan #30: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain, Insomnia Treatment.

Decision rationale: Toprophan is comprised of vitamin B6, L-tryptophan, camomille, valerian extract, melatonin, inositol and other ingredients. The Official Disability Guidelines note pharmacological agents should only be used after careful evaluation of potential causes of sleep disturbance. Failure of sleep disturbance to resolve in a 7 to 10 day period may indicate a psychiatric and/or medical illness. The guidelines recommend the use of melatonin for insomnia. It is recommended that treatments for insomnia should reduce time to sleep onset, improve sleep maintenance, avoid residual effects and increase next-day functioning. There is a lack of documentation indicating the injured worker has significant insomnia. The requesting physician's rationale for the request is not indicated within the provided documentation. There is a lack of documentation indicating the injured worker has significant objective improvement in sleep hygiene with the medication. Additionally, the request does not indicate the frequency at which the medication is prescribed in order to determine the necessity of the medication. As such, the request is not medically necessary.

Keto-Cap Ultracream: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 112-113. Decision based on Non-MTUS Citation Official Disability Guidelines.

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

Decision rationale: The California MTUS Guidelines state topical analgesics are recommended as an option in use 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 California MTUS Guidelines recommend the use of capsaicin for patients with osteoarthritis, postherpetic neuralgia, diabetic neuropathy, and post mastectomy pain. The guidelines recommend the use of capsaicin only as an option in patients who have not responded or are intolerant to other treatments. The California MTUS guidelines recommend the use of topical NSAIDs for patients with osteoarthritis and tendinitis, in particular, that of the knee and elbow or other joints that are amenable to topical treatment for short-term use (4-12 weeks). There is little evidence to utilize topical NSAIDs for treatment of osteoarthritis of the spine, hip or shoulder. There is no evidence that the injured worker has tried other prescription medications including antidepressants or anticonvulsants. There is no indication that the injured worker has osteoarthritis or tendinitis to a joint that is amenable to topical treatment. There is no indication the injured worker's medications have been decreased or have not been tolerated. Additionally, the request does not indicate the frequency at which the

medication is prescribed and the site at which it is to be applied in order to determine the necessity of the medication. As such, the request is not medically necessary.