

Case Number:	CM14-0079144		
Date Assigned:	07/18/2014	Date of Injury:	07/01/1999
Decision Date:	10/17/2014	UR Denial Date:	05/06/2014
Priority:	Standard	Application Received:	05/29/2014

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 Anesthesiology, has a subspecialty in Pain Management, 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:

According to the records made available for review, this is a 50-year-old male with a 7/1/99 date of injury. At the time (4/15/14) of request for authorization for Voltaren XR (Diclofenac ER) 100mg #30, Flurbiprofen 20% 120gm cream, Ketoprofen 20%/Ketamine 10% 120gm cream, and Gabapentin 10%/Cyclobenzaprine 10%/Capsaicin 0.0375% 120gm cream, there is documentation of subjective (moderate to severe low back pain radiating to the buttocks, legs, knees and feet) and objective (tenderness to palpation from L3 to the sacrum with spasms, decreased lumbar range of motion, positive straight leg raise test, and decreased strength of the extensor hallucis longus) findings, current diagnoses (lumbar disc protrusions and long history of intermittent sciatica with radiation to the lower extremities), and treatment to date (physical therapy and medications (including ongoing therapy with Naproxen)). Medical report identifies a request for a trial of Voltaren and topical creams. Regarding Flurbiprofen 20% 120gm cream, there is no documentation of osteoarthritis pain in joints that lend themselves to topical treatment (ankle, elbow, foot, hand, knee, and wrist) and failure of an oral NSAID or contraindications to oral NSAIDs.

IMR ISSUES, DECISIONS AND RATIONALES

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

Voltaren XR (diclofenac ER) 100mg #30: Overturned

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs (non-steroidal anti-inflammatory drugs) Page(s): 67-68. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Diclofenac sodium (Voltaren, Voltaren-XR)

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines identifies documentation of moderate to severe osteoarthritis pain, acute low back pain, chronic low back pain, or exacerbations of chronic pain, as criteria necessary to support the medical necessity of NSAIDs. ODG identifies that Voltaren is not used as first line therapy due to increased risk profile. Within the medical information available for review, there is documentation of diagnoses of lumbar disc protrusions and long history of intermittent sciatica with radiation to the lower extremities. In addition, there is documentation of chronic low back pain. Furthermore, there is documentation of Voltaren used as second line therapy. Therefore, based on guidelines and a review of the evidence, the request for Voltaren XR (Diclofenac ER) 100mg #30 is medically necessary.

Flurbiprofen 20% 120gm cream: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Non-steroidal anti-inflammatory agents (NSAIDs) Page(s): 111-112. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Topical analgesics

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines identifies documentation of osteoarthritis pain in joints that lend themselves to topical treatment (ankle, elbow, foot, hand, knee, and wrist) and short-term use (4-12 weeks), as criteria necessary to support the medical necessity of topical NSAIDs. ODG identifies documentation of failure of an oral NSAID or contraindications to oral NSAIDs. Within the medical information available for review, there is documentation of diagnoses of lumbar disc protrusions and long history of intermittent sciatica with radiation to the lower extremities. In addition, there is documentation of chronic low back pain. Furthermore, given documentation of a request for a trial of topical creams, there is documentation of an indication for short-term use (4-12 weeks). However, despite documentation of chronic pain, there is no (clear) documentation of osteoarthritis pain in joints that lend themselves to topical treatment (ankle, elbow, foot, hand, knee, and wrist). In addition, given documentation of an associated request for oral Voltaren, there is no documentation of failure of an oral NSAID or contraindications to oral NSAIDs. Therefore, based on guidelines and a review of the evidence, the request for Flurbiprofen 20% 120gm cream is not medically necessary.

Ketoprofen 20%/Ketamine 10% 120gm cream: Upheld

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

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

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines identifies that many agents are compounded as monotherapy or in combination for pain control; that Ketoprofen, Lidocaine (in creams, lotion or gels), Capsaicin in a 0.0375% formulation, Baclofen and other muscle relaxants, and Gabapentin and other antiepilepsy drugs are not recommended for topical applications; and that any compounded product that contains at least one drug (or drug class) that is not recommended, is not recommended. Within the medical information available for review, there is documentation of diagnoses of lumbar disc protrusions and long history of intermittent sciatica with radiation to the lower extremities. However, the requested compounded medication consists of at least one drug (Ketoprofen) that is not recommended. Therefore, based on guidelines and a review of the evidence, the request for Ketoprofen 20%/Ketamine 10% 120gm cream is not medically necessary.

Gabapentin 10%/cyclobenzaprine 10%/capsaicin 0.0375% 120gm cream: Upheld

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

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

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines identifies that many agents are compounded as monotherapy or in combination for pain control; that Ketoprofen, Lidocaine (in creams, lotion or gels), Capsaicin in a 0.0375% formulation, Baclofen and other muscle relaxants, and Gabapentin and other antiepilepsy drugs are not recommended for topical applications; and that any compounded product that contains at least one drug (or drug class) that is not recommended, is not recommended. Within the medical information available for review, there is documentation of diagnoses of lumbar disc protrusions and long history of intermittent sciatica with radiation to the lower extremities. However, the requested compounded medication consists of at least one drug (Capsaicin in a 0.0375% formulation and Gabapentin) and one drug class (muscle relaxants) that is not recommended. Therefore, based on guidelines and a review of the evidence, the request for Gabapentin 10%/Cyclobenzaprine 10%/Capsaicin 0.0375% 120gm cream is not medically necessary.