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| Case Number: | CM14-0084522 | | |
| Date Assigned: | 07/21/2014 | Date of Injury: | 03/19/2011 |
| Decision Date: | 10/03/2014 | UR Denial Date: | 05/21/2014 |
| Priority: | Standard | Application Received: | 06/06/2014 |

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 66-year-old female who reported an injury due to lifting a patient to perform care on 03/19/2011. On 12/13/2013, her diagnoses included herniated nucleus pulposus with spinal cord compression at C3-4, C4-5, C5-6 and C6-7 with progressive neurological deficit, bilateral upper extremity radiculopathy and myelopathy, status post left sided L4-5 microdiscectomy, and anxiety and depression secondary to industrial injury. Her medications included Omeprazole, Norco and Ultracet, of unknown dosages, plus 3 topical compounded creams. Her complaints included constant neck pain rated at 9/10 with radiation to the bilateral extremities, constant low back pain rated at 9/10 with radiation to the bilateral lower extremities and abdominal pain associated with burning sensation due to her medications. On 04/21/2014, her diagnoses and complaints remained the same, but the Ultracet was removed from her medication regimen. There was no rationale or Request for Authorization included in this injured worker's chart.

IMR ISSUES, DECISIONS AND RATIONALES

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

Prilosec 20 mg #30: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs (non-steroidal anti-inflammatory drugs), GI symptoms & cardiovascular risk Page(s): 68-69.

Decision rationale: The request for Prilosec 20 mg #30 is not medically necessary. The California MTUS Guidelines suggest that proton pump inhibitors, which includes Prilosec, may be recommended, but clinician's should weigh the indications for NSAIDs against GI risk factors. Those factors determining of a patient is at risk for gastrointestinal events include age greater than 65 years, history of peptic ulcer, GI bleeding or perforation, concurrent use of aspirin, corticosteroids, and/or anticoagulants or high-dose/multiple NSAID use. Prilosec is used in the treatment of dyspepsia, peptic ulcer disease, gastroesophageal reflux disease and laryngopharyngeal reflux. The injured worker did not have any of the above diagnoses nor did she meet any of the qualifying criteria for risk for gastrointestinal events other than being over the age of 65. Additionally, the request did not specify a frequency of administration. Therefore, this request for Prilosec 20 mg #30 is not medically necessary.

Flurbiprofen 20% cream 120 gm: 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: The request for Flurbiprofen 20% cream 120 g is not medically necessary. The California MTUS Guidelines refer to topical analgesics as largely experimental with few randomized controlled trials to determine efficacy or safety. They are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Many agents are compounded for pain. There is little to no research to support the use of many of these agents. Any compounded product that contains at least 1 drug or drug class that is not recommended is not recommended. The only FDA approved NSAID for topical application is Voltaren gel 1% (Diclofenac), which is indicated for relief of osteoarthritis pain in joints that lend themselves to topical treatment. The guidelines do not support Flurbiprofen for topical application. Additionally, the body part or parts to which this cream would have been applied or a frequency of application were not specified in the request. Therefore, this request for Flurbiprofen 20% cream 120 g is not medically necessary.

Ketoprofen 20% and Ketamine 10% cream 120 gm: 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: The request for Ketoprofen 20% and Ketamine 10% cream 120 g is not medically necessary. The California MTUS Guidelines refer to topical analgesics as largely

experimental with few randomized controlled trials to determine efficacy or safety. They are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Ketoprofen is not currently FDA approved for topical application. It has an extremely high incidence of photocontact dermatitis. Additionally, the body part or parts to which this cream would have been applied or a frequency of application were not specified in the request. The guidelines do not support the use of this compounded cream. Therefore, the request for Ketoprofen 20% and Ketamine 10% cream 120 g is not medically necessary.

Gabapentin 10% and Cyclobenzaprine 10% with 0.375% Capsaicin cream 120 gm: 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: The request for Gabapentin 10% and Cyclobenzaprine 10% with 0.375% Capsaicin cream 120 g is not medically necessary. The California MTUS Guidelines refer to topical analgesics as largely experimental with few randomized controlled trials to determine efficacy or safety. They are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Many agents are compounded in combination for pain control including capsaicin and antiepileptic medications. There is little to no research to support the use of many of these agents. Any compounded product that contains at least 1 drug or drug class that is not recommended is not recommended. Capsaicin is generally available as a 0.025% formulation as a treatment for osteoarthritis. There have been no studies of a 0.375% formulation of Capsaicin and there is no current indication that this increase over 0.025% formulation will provide any further efficacy. Gabapentin is not recommended. There is no peer reviewed literature to support its use. The guidelines do not support the use of this compounded medication. Therefore, the request for Gabapentin 10% and Cyclobenzaprine 10% with 0.375% Capsaicin cream 120 g is not medically necessary.