

Case Number:	CM14-0194100		
Date Assigned:	12/01/2014	Date of Injury:	07/18/2008
Decision Date:	01/21/2015	UR Denial Date:	11/06/2014
Priority:	Standard	Application Received:	11/19/2014

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 Rehab, has a subspecialty in Pain Medicine, and is licensed to practice in Texas. 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 48 year-old female who reported an injury on 07/18/2008. The mechanism of injury was not specifically stated. The current diagnoses include lumbago, myofascial pain syndrome, reflex sympathetic dystrophy of the lower limb and reflex sympathetic dystrophy of the upper limb. The injured worker presented on 05/10/2013 with complaints of persistent 9/10 pain. The current medication regimen includes Oxycodone 30 mg, Lidoderm 5% patch, Biofreeze Roll-On tube, and a compounded cream containing Ketoprofen 20%, and Capsaicin 0.0275%. Physical examination revealed 2/5 motor weakness in the right upper extremity, 4/5 motor weakness in the right lower extremity, tenderness to palpation of the lumbar spine, and intact sensation. Treatment recommendations included continuation of the current medication regimen. There was no Request for Authorization Form submitted for this review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retrospective: Cyclobenzaprine/Gabapentin/Ketoprofen/Lidocaine/Flurbiprofen topical cream DOS: 06/03/2013: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical analgesics Page(s): 143.

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

Decision rationale: 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 one drug that is not recommended, is not recommended as a whole. The only FDA approved topical NSAID is Diclofenac. Therefore, the request for a compounded cream containing Ketoprofen and Flurbiprofen is not medically appropriate. Additionally, muscle relaxants are not recommended as a topical product. Gabapentin is also not recommended as a topical product, as there is no peer reviewed literature to support its use. No commercially approved topical formulation of lidocaine in a cream, lotion, or gel is indicated. Based on the clinical information received, the current request is not medically necessary and appropriate.