

Case Number:	CM14-0196479		
Date Assigned:	12/04/2014	Date of Injury:	06/12/2007
Decision Date:	01/23/2015	UR Denial Date:	11/11/2014
Priority:	Standard	Application Received:	11/24/2014

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 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:

This is a 65-year-old male with a 6/12/07 date of injury. The patient was seen on 10/30/14 with complaints of persistent pain in the neck, mid back, lower back, and left knee. Exam findings revealed tenderness over cervical paraspinals, lumbar paraspinals, trapezius and over the medial and lateral joint line. The right Spurling's test, shoulder depression test, left SLR test and McMurray's tests were positive. The patient was utilizing Kera-tec gel, which helped him. The diagnosis is multilevel cervical/lumbar disc herniation, left knee strain, right trigger thumb, and right carpal tunnel syndrome. Treatment to date: work restrictions, physical therapy, topical creams and medications. An adverse determination was received on 11/11/14, however the determination page was not available for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Diclofenac/lidocaine 3%/5% 180gm: 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: CA MTUS Chronic Pain Medical Treatment Guidelines state that ketoprofen, NSAIDs, lidocaine (in creams, lotion or gels), are not recommended for topical applications. In addition, any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Additionally, CA MTUS Chronic Pain Medical Treatment Guidelines recommend Diclofenac in a 1% formulation for the relief of osteoarthritis pain in joints that lend themselves to topical treatment (ankle, elbow, foot, hand, knee, and wrist). However, it is unclear why a 3% formulation would be required in this patient. In addition, there remains sparse documentation as to why the prescribed compound formulation would be required despite adverse evidence. Therefore, the request for Diclofenac/lidocaine 3%/5% 180gm was not medically necessary.