

Case Number:	CM15-0005769		
Date Assigned:	01/26/2015	Date of Injury:	07/25/2007
Decision Date:	04/08/2015	UR Denial Date:	12/17/2014
Priority:	Standard	Application Received:	01/12/2015

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
 State(s) of Licensure: New York
 Certification(s)/Specialty: Pediatrics, Internal Medicine

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 37 year old male who sustained an industrial injury on July 25, 2007. He has reported neck pain, headaches, bilateral upper extremity pain, mid back pain, and low back pain and has been diagnosed with status post anterior cervical discectomy and fusion surgery at C6-C7, status post anterior posterior lumbar fusion surgery, thoracic spine sprain/strain, cervical spine myofascial pain syndrome, and lumbar spine myofascial pain syndrome. Treatment to date has include medical imaging, surgery, pain medication as well as topical medications, Currently the injured worker complains of neck pain, headaches, bilateral upper extremity pain, mid back pain, and lower back pain. The treatment plan included topical pain medications. On December 17, 2014 Utilization Review non certified flurbiprofen 20% gel 120 gm, ketoprofen 20 % /ketamine 10% gel 120 gm, gabapentin 10% /cyclobenzaprine 10%/ capsaicin0.375% gel 120 gm, and 1 follow up visit with pain management.

IMR ISSUES, DECISIONS AND RATIONALES

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

Flurbiprofen 20% gel 120gm: 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: Topical NSAID's are indicated for treatment of osteoarthritis and tendinitis, in particular, that of the knee and elbow or other joints that are amenable to topical treatment. They are recommended for short-term use. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Flurbiprofen is not FDA approved for topical use. This request is not medically necessary and appropriate at this time.

Retrospective Ketoprofen/Ketamine gel 120gm: Upheld

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

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

Decision rationale: Topical NSAID's are indicated for treatment of osteoarthritis and tendinitis, in particular, that of the knee and elbow or other joints that are amenable to topical treatment. They are recommended for short-term use. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Ketoprofen is not FDA approved for topical use. Topical ketamine is only recommended for treatment of neuropathic pain in refractory cases in which all primary and secondary treatment has been exhausted. This request is not medically necessary and appropriate at this time.

Retrospective Gaba/Cyclo/Caps gel 120gm: 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: Topical NSAID's are indicated for treatment of osteoarthritis and tendinitis, in particular, that of the knee and elbow or other joints that are amenable to topical treatment. They are recommended for short-term use. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Cyclobenzaprine and gabapentin are not FDA approved for topical use. Topical capsaicin is only recommended as an option in patients who have not responded or are intolerant to other treatments. This request is not medically necessary and appropriate at this time.

Retrospective follow-up with pain management specialist: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Chronic pain disorder medical treatment guidelines, state of Colorado, department of labor and employment, page 56.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic pain programs Page(s): 30-32.

Decision rationale: Indications for referral to pain management include all of the following: (1) An adequate and thorough evaluation has been made, including baseline functional testing so follow-up with the same test can note functional improvement; (2) Previous methods of treating chronic pain have been unsuccessful and there is an absence of other options likely to result in significant clinical improvement; (3) The patient has a significant loss of ability to function independently resulting from the chronic pain; (4) The patient is not a candidate where surgery or other treatments would clearly be warranted (if a goal of treatment is to prevent or avoid controversial or optional surgery, a trial of 10 visits may be implemented to assess whether surgery may be avoided); (5) The patient exhibits motivation to change, and is willing to forgo secondary gains, including disability payments to effect this change; & (6) Negative predictors of success above have been addressed. According to the documentation provided the IW has had intolerance to oral medications with gastritis but is not clear what medications he has been on in the past and that there is a lack of further options. There is also no documentation of a lack of independent function due to the pain. This request is not medically necessary and appropriate at this time.