

| | | | |
|-----------------------|--------------|------------------------------|------------|
| Case Number: | CM15-0135125 | | |
| Date Assigned: | 07/23/2015 | Date of Injury: | 02/02/2013 |
| Decision Date: | 08/19/2015 | UR Denial Date: | 07/10/2015 |
| Priority: | Standard | Application Received: | 07/13/2015 |

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: Iowa, Illinois, Hawaii

Certification(s)/Specialty: Preventive Medicine, Occupational Medicine, Public Health & General Preventive 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 51 year old male, who sustained an industrial injury on 2/2/13. The diagnoses have included status post left shoulder arthroscopy with rotator cuff repair. Treatment to date has included medications, activity modifications, surgery, diagnostics, and home exercise program (HEP). Currently, as per the physician progress note dated 6/19/15, the injured worker complains of left shoulder pain, left shoulder stiffness and left arm grinding. The objective findings reveal crepitus with range of motion of the left shoulder and weakness with left shoulder abduction. The diagnostic testing that was performed included Magnetic Resonance Imaging (MRI) of the left shoulder with arthrogram. The current medications included Relafen and topical compounded analgesic creams. There is no previous urine drug screen noted. The physician requested treatments included Relafen 500mg #60 with 4 refills, Topical cream Flurbiprofen 20% and Lidocream 5% 240gms and Topical cream Lidocaine 6%/Gabapentin 10%/Ketoprofen 10% 240gms.

IMR ISSUES, DECISIONS AND RATIONALES

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

Relafen 500mg #60 with 4 refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs (non-steroidal anti-inflammatory drugs).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs; Relafen Page(s): 67- 72.

Decision rationale: MTUS recommends the use of NSAIDS for the acute exacerbation of back pain at the lowest effective dose for the shortest amount of time due to the increased cardiovascular risk, renal, hepatic and GI side effects associated with long-term use. MTUS states "Nabumetone (Relafen, generic available): 500, 750 mg. Dosing: Osteoarthritis: The recommended starting dose is 1000 mg PO. The dose can be divided into 500 mg PO twice a day. Additional relief may be obtained with a dose of 1500 mg to 2000 mg per day. The maximum dose is 2000 mg/day. Patients weighing less than 50 kg may be less likely to require doses greater than 1000 mg/day. The lowest effective dose of nabumetone should be sought for each patient. Use for moderate pain is off-label. (Relafen Package Insert)". The patient has been prescribed Relafen without any significant improvement in pain, quality of life, or functionality. The treating physician has not provided any justification to exceed MTUS guidelines of "at the lowest effective dose for the shortest amount of time". As such, the request for Relafen 500mg #60 with 4 refills is not medically necessary.

Topical cream Flurbiprofen 20% and Lidocream 5% 240gms jar: 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 based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Compound creams.

Decision rationale: MTUS and ODG recommends usage of topical analgesics as an option, but also further details "primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed.: The medical documents do not indicate failure of antidepressants or anticonvulsants. MTUS states, "There is little to no research to support the use of many of these agents. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended." MTUS states that the only FDA- approved NSAID medication for topical use includes diclofenac, which is indicated for relief of osteoarthritis pain in joints. Flurbiprofen would not be indicated for topical use in this case. As such, the request for Topical cream Flurbiprofen 20% and Lidocream 5% 240gms jar is not medically necessary.

Topical cream Lidocaine 6%/Gabapentin 10%/Ketoprofen 10% 240gms jar: 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 based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Compound creams.

Decision rationale: MTUS and ODG recommends usage of topical analgesics as an option, but also further details "primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed." The medical documents do not indicate failure of antidepressants or anticonvulsants. MTUS states, "There is little to no research to support the use of many of these agents. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended." MTUS states that topical Gabapentin is "Not recommended." And further clarifies, "anti-epilepsy drugs: There is no evidence for use of any other anti-epilepsy drug as a topical product." As such, the request for Topical cream Lidocaine 6%/Gabapentin 10%/Ketoprofen 10% 240gms jar is not medically necessary.