

Case Number:	CM15-0136174		
Date Assigned:	07/24/2015	Date of Injury:	09/10/2013
Decision Date:	09/18/2015	UR Denial Date:	06/16/2015
Priority:	Standard	Application Received:	07/14/2015

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: Maryland

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Neuromuscular 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 male worker who sustained an industrial injury on September 10, 2013. A primary treating office visit dated May 18, 2015 reported subjective complaint of low back pain with increasing right lower extremity symptoms; thoracic pain, left knee pain, right knee pain, and bilateral shoulder pain. He states being recently diagnosed with gastritis and that a recent compound topical trial was found to be beneficial and noted more effective than oral NSAID's. Current medication regimen included: Hydrocodone 10mg BID and Flexeril. He noted with inquiry regarding tapering of medications. The following diagnoses were applied: neural encroachment bilateral L4-5 with radiculopathy; facet osteoarthropathy L5 and S1; thoracic myofascial pain; left knee pain; left shoulder pain, and cervical pain with upper extremity symptoms. The plan of care noted proceeding with cardiac clearance, lumbar decompression and post-operative course of physical therapy. In addition, there is recommendation to obtain and use a topical compound cream Ketoprofen. A follow up dated April 20, 2015 reported unchanged subjective complaint. The plan of care noted with standing recommendation to utilize a topical compound cream Ketoprofen.

IMR ISSUES, DECISIONS AND RATIONALES

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

Cyclobenzaprine 10mg #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants (for pain) Page(s): 63-66.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Cyclobenzaprine (Flexeril) and Muscle relaxants (for pain) Page(s): 41-42 and 64 and 63.

Decision rationale: Cyclobenzaprine 10mg #30 is not medically necessary per the MTUS Chronic Pain Medical Treatment Guidelines. The guidelines state that Cyclobenzaprine is not recommended to be used for longer than 2-3 weeks. The documentation indicates that the patient has already been on Cyclobenzaprine. There are no extenuating circumstances documented that would necessitate continuing this medication beyond the 2-3 week MTUS recommended time period for this medication. The request for Cyclobenzaprine is not medically necessary.

Ketoprofen 10% cream, 300 grams, with 3 refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 25, 28, 111-113.

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

Decision rationale: Ketoprofen 10% cream, 300 grams, with 3 refills is not medically necessary per the MTUS Chronic Pain Medical Treatment Guidelines. The MTUS states that topical analgesics are largely experimental in use 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. The MTUS states any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. The guidelines indicate that Ketoprofen topically is not currently FDA approved for a topical application. It has an extremely high incidence of photocontact dermatitis. The documentation does not indicate extenuating circumstances that necessitate a topical medication that is not FDA approved and has a high incidence of adverse side effects therefore this request is not medically necessary.