

Case Number:	CM15-0196772		
Date Assigned:	11/04/2015	Date of Injury:	03/22/2006
Decision Date:	12/15/2015	UR Denial Date:	09/24/2015
Priority:	Standard	Application Received:	10/06/2015

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: 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 57 year old female, who sustained an industrial injury on 01-01-1990. The injured worker is currently temporarily totally disabled. Medical records indicated that the injured worker is undergoing treatment for status post anterior cervical discectomy and fusion. Treatment and diagnostics to date has included physical therapy, cervical spine surgery, cervical spine x-rays, and medications. Recent medications have included Norco and Flexeril. Subjective data (04-21-2015 and 09-01-2015), included neck pain rated 8 out of 10 with radiation to the right upper extremity. Objective findings (09-01-2015) included "a swollen trapezius muscle" and weakness with abduction of arm above the head. The request for authorization dated 09-01-2015 requested right shoulder MRI, physical therapy of the cervical spine, Voltaren XR, Norco, and topical creams. The Utilization Review with a decision date of 09-23-2015 non-certified the request for MRI of the right shoulder, Voltaren XR 100mg #30, Flurbiprofen 20% 120gm, Ketoprofen-Ketamine 20-10% 120gm, and Cyclobenzaprine-Gabapentin-Capsaicin 10-10-0.0375% 120gm.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI of the right shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS Shoulder Complaints 2004, Section(s): Special Studies.

MAXIMUS guideline: Decision based on MTUS Shoulder Complaints 2004, Section(s): Special Studies.

Decision rationale: MTUS recommends ordering imaging studies when there is evidence of a red flag on physical examination (e.g., indications of intra-abdominal or cardiac problems presenting as shoulder problems), failure to progress in a strengthening program intended to avoid surgery or clarification of the anatomy prior to an invasive procedure (e.g., a full thickness rotator cuff tear not responding to conservative treatment). The injured worker complains of neck pain radiating to the right upper extremity. Physician report indicates the injured worker reports a history of shoulder issue. There is no report of plain X-ray imaging of the shoulder. Chart documentation further fails to show objective evidence of red flags that would establish the medical necessity for MRI. The request for MRI of the right shoulder is not medically necessary by MTUS.

Voltaren XR 100mg #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain (Chronic) Voltaren.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Anti-inflammatory medications.

Decision rationale: Per MTUS, Non-steroidal anti-inflammatory drugs (NSAIDS) are recommended at the lowest dose for the shortest period in patients with moderate to severe pain. Acetaminophen may be considered for initial therapy for patients with mild to moderate pain, and in particular, for those with gastrointestinal, cardiovascular or renovascular risk factors. There is no evidence of long-term effectiveness for pain or function. NSAIDS are recommended as a second-line treatment after acetaminophen for the treatment of acute exacerbations of chronic low back pain. The injured worker complains of persistent radicular neck pain. The recommendation for NSAID use is appropriate. However, MTUS recommends Voltaren XR only for use as chronic maintenance therapy. There is lack of evidence that first line NSAIDS have been tried and failed. With MTUS guidelines not being met, the request for Voltaren XR 100mg #30 is not medically necessary.

Flurbiprofen 20% 120gm: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Topical Analgesics.

Decision rationale: MTUS states that use of topical analgesics is primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. There is little to no research to support the use of many of these agents. Flurbiprofen is not FDA approved for topical application. Per guidelines, any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. The request for Flurbiprofen 20% 120gm is not medically necessary.

Ketoprofen/Ketamine 20/10%, 120gm: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Topical Analgesics.

Decision rationale: MTUS states that topical NSAIDs are not recommended for neuropathic pain, but may be useful for short-term treatment (4-12 weeks) of osteoarthritis pain in joints that lend themselves to topical treatment (ankle, elbow, foot, hand, knee, and wrist). Topical NSAIDs have not been evaluated for treatment of the spine, hip or shoulder. There are no long-term studies of their effectiveness or safety. MTUS does not recommend the use of ketamine for the treatment of chronic pain. Furthermore, MTUS does not recommend Ketoprofen and this medication is not currently FDA approved for a topical application. Per guidelines, any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. The request for Ketoprofen/Ketamine 20/10%, 120gm is not medically necessary.

Cyclobenzaprine, Gabapentin, Capsaicin 10/10/0.0375%, 120gm: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Topical Analgesics.

Decision rationale: MTUS states that use of topical analgesics is primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. There is little to no research to support the use of many of these agents. MTUS does not recommend the use of Cyclobenzaprine (muscle relaxant) or Gabapentin as topical agents. Capsaicin is generally available as a 0.025% formulation (as a treatment for osteoarthritis) and a 0.075% formulation (primarily studied for post-herpetic neuralgia, diabetic neuropathy and post-mastectomy pain). There have been no studies of a 0.0375% formulation of capsaicin and there is no current indication that this increase over a 0.025% formulation would provide any further efficacy. Per guidelines, any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. The request for Cyclobenzaprine, Gabapentin, Capsaicin 10/10/0.0375%, 120 gm is not medically necessary.