MAXIMUS Federal Services

Case Number:	CM15-0218643		
Date Assigned:	11/10/2015	Date of Injury:	10/22/2013
Decision Date:	12/31/2015	UR Denial Date:	11/03/2015
Priority:	Standard	Application Received:	11/06/2015

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: California, Indiana, 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 10-22-13. The injured worker reported right upper extremity pain. A review of the medical records indicates that the injured worker is undergoing treatments for complex regional pain syndrome of unspecified upper limb and pain in unspecified hand. Medical records dated 10-21-15 indicate pain rated at 6 out of 10 with the use of medication. Medical records dated 6-24-15 indicated pain rated at 8 out of 10 with the use of medication. Provider documentation dated 10-21-15 noted the work status as permanent and stationary. Treatment has included Lyrica since at least September of 2015, home exercise program, status post right wrist repair (1-9-14), acupuncture treatment, physical therapy, Psychotherapy, nerve root blocks, and right wrist compression glove. Objective findings dated 10-21-15 were notable for hyperesthesia over medial hand and lateral hand on the right. The original utilization review (11-3-15) denied a request for Trial topical compound cream (K cream).

IMR ISSUES, DECISIONS AND RATIONALES

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

Trial topical compound cream (K cream): 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 based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain section, Topical analgesics.

Decision rationale: Pursuant to the Chronic Pain Medical Treatment Guidelines and the Official Disability Guidelines, Trial topical compound cream (K cream) is not medically necessary. Topical analgesics are largely experimental with few controlled trials to determine efficacy and safety. They are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Other than Lidoderm, no other commercially approved topical formulation of Lidocaine whether cream, lotions or gels are indicated for neuropathic pain. In this case, the injured worker's working diagnoses are right hand injury; right upper extremity complex regional pain syndrome; right knee pain; and left elbow pain. Date of injury is October 22nd 2013. Request for authorization is October 27, 2015. There are no services listed in the body of the request for authorization. According to an October 21, 2015 progress note, subjective complaints include right upper extremity pain 6/10. Objectively, there are trophic changes in the hand with decreased range of motion. The treating provider requested K cream. The treating provider does not indicate what the K stands for. The utilization review designates K cream- Ketamine. Ketamine is not recommended except for treatment of neuropathic pain in refractory cases in which all primary and secondary treatment has been exhausted. There is no documentation of failed first-line treatment. There is no documentation of fail antidepressants are anticonvulsants. Ketamine is not recommended. Based on clinical information in the medical record, peer-reviewed evidence-based guidelines and unclear documentation indicating the component/ ingredient in K cream, Trial topical compound cream (K cream) is not medically necessary.