

Case Number:	CM15-0044901		
Date Assigned:	03/17/2015	Date of Injury:	02/06/2013
Decision Date:	04/24/2015	UR Denial Date:	02/12/2015
Priority:	Standard	Application Received:	03/10/2015

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

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Pain Management

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 56 year old male who sustained an industrial injury on 02/06/2013. The injured worker sustained an injury while driving and had a twisting injury of his right shoulder. Diagnoses include right rotator cuff tear, and status post arthroscopic shoulder surgery and clavicle resection on 11/27/2013 and partial co-planing of the clavicle date not known, and a torn meniscus left knee status post arthroscopic knee surgery on 5/21/2014. Treatment to date has included medications, physical therapy, and prior surgeries. A physician progress note dated 10/16/2014 documents the injured worker continues to complain of right shoulder pain and tenderness. In addition, the injured worker also states that he injured his bilateral elbows, bilateral knees, cervical and lumbar spine and would like this physician to take over care in that regard. Magnetic Resonance Imaging and x-rays revealed a significant torn rotator cuff. On 12/06/2014 a physician progress note documents the injured worker is doing poorly and has developed depression secondary to his persistent pain from his industrial injury. He has tenderness present in his right shoulder. The physician is requesting a psychiatric consultation and medications. Treatment requested is for Gabapentin/Pyridoxine 250/10mg #120, and Keratek Gel 4oz bottle.

IMR ISSUES, DECISIONS AND RATIONALES

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

Gabapentin/Pyridoxine 250/10mg #120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 16-19. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Vitamin B.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antiepileptic Medications Page(s): 16-21.

Decision rationale: Regarding request for gabapentin, Chronic Pain Medical Treatment Guidelines state that antiepilepsy drugs are recommended for neuropathic pain. They go on to state that a good outcome is defined as 50% reduction in pain and a moderate response is defined as 30% reduction in pain. Guidelines go on to state that after initiation of treatment, there should be documentation of pain relief and improvement in function as well as documentation of side effects incurred with use. The continued use of AEDs depends on improved outcomes versus tolerability of adverse effects. Within the documentation available for review, there is no diagnosis or exam finding consistent with neuropathic pain. Chronic Pain Medical Treatment Guidelines state that any compounded product that contains at least one drug or drug class that is not recommended, is not recommended. In the absence of such documentation, the currently requested gabapentin/pyridoxine is not medically necessary.

Keratek Gel 4oz bottle: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Salicylate Topics, Topical Analgesics Page(s): 105, 111.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical NSAIDs Page(s): 105, 111-113.

Decision rationale: With regard to the request for Keratek, this is a topical formulation consisting of menthol and methyl salicylate. The California Medical Treatment Utilization Schedule does not have specific guidelines regarding menthol. The Chronic Pain Medical Treatment Guidelines on page 105 states the following with regard to salicylate topicals: "Recommended. Topical salicylate (e.g., Ben-Gay, methyl salicylate) is significantly better than placebo in chronic pain. (Mason-BMJ, 2004)" Furthermore, methyl salicylate is known to metabolize into salicylic acid which is a known NSAID. The guidelines of topical NSAIDs recommend use for the short-term (4-12 weeks) in joints that are amenable to topical therapy. Within the documentation available for review, there is no documentation that the patient would be unable to tolerate oral NSAIDs, which would be preferred. A progress note on 12/4/2014 indicated the patient was prescribed oral flurbiprofen without any documented adverse effects on oral NSAIDs. Furthermore, the patient was concurrently prescribed diclofenac topical treatment without clear explanation of why two different topical formulations of NSAIDs were necessary. Lastly, there is no indication that this topical treatment is prescribed for short term use, as recommended by guidelines. In the absence of clarity regarding those issues, the currently requested topical Keratek is not medically necessary.

