

Case Number:	CM14-0005162		
Date Assigned:	01/24/2014	Date of Injury:	03/10/2009
Decision Date:	06/19/2014	UR Denial Date:	12/12/2013
Priority:	Standard	Application Received:	01/14/2014

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. The expert reviewer is Board Certified in Anesthesiology Pain Medicine and is licensed to practice in Florida. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 female who reported an injury on 03/10/2009. The mechanism of injury was not provided. The clinical note dated 12/16/2013 reported the injured worker complained of bilateral shoulder pain, hand and elbow pain and neck pain radiating to bilateral upper extremities. The physical examination revealed a positive impingement and Hawkins sign in the right shoulder with decreased range of motion to include less than 80 degrees abduction, 90 degrees flexion and deltoid strength of 4/5. A positive impingement and Hawkins sign were noted to the left shoulder and spasms, tenderness and guarding were noted in the paravertebral musculature of the lumbar spine. The clinical note also stated the injured worker has undergone extensive conservative management in the form of therapy, medications and cortisone injections. The diagnoses included sprain/strain of the neck, thoracic or lumbosacral neuritis or radiculitis, olecranon bursitis, and enthesopathy of the wrist. The request for authorization was not provided.

IMR ISSUES, DECISIONS AND RATIONALES

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

PRESCRIPTION OF CA PO .37%/MENT 10%/ CA MP2%: 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): 111-112.

Decision rationale: The request for Prescription of CA PO .37%/Ment 10%/CA MP 2% is non-certified. The injured worker has a history of bilateral shoulder pain, hand and elbow pain and neck pain radiating to bilateral upper extremities treated with surgery, medications and cortisone injections and therapy. The CA MTUS Guidelines state topical analgesics are largely experimental and Capsaicin is only recommend as an option in injured workers who have not responded or are intolerant to other treatments. The guidelines also state 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. While the clinical information, provided for review, stated the injured worker has attempted extensive conservative care to include therapy, medication and cortisone injections and continues to be symptomatic the guidelines clearly state an increase of 0.0375% formulation of capsaicin over a 0.025% formulation would not provide any further efficacy. It did not appear the injured worker had not responded or was intolerant to other treatments. Therefore, the request for Prescription of CA PO .37%/Ment 10%/CA MP 2% is not medically necessary and appropriate.

CYCLO/KETO 10/3% VC 120GM: 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 rationale: The request for Cyclo/Keto 10/3% VC 20GM is non-certified. The injured worker has a history of bilateral shoulder pain, hand and elbow pain and neck pain radiating to bilateral upper extremities treated with surgery, medications and cortisone injections and therapy. The current CA MTUS Guidelines states any compounded product that contains at least one drug or drug class that is not recommended is not recommended. The guidelines also state there is no evidence for use of the muscle relaxant cyclobenzprine as a topical product. The guidelines recommend NSAIDS for osteoarthritis and tendinitis, in particular, that of the knee and elbow or other joints that are amenable to topical treatment. The clinical information, provided for review, states the injured worker has attempted extensive conservative care to include therapy, medication and cortisone injections and continues to be symptomatic; the guidelines clearly state Cyclobenzaprine is a muscle relaxant that is not recommended for topical treatment. Therefore, per the guidelines any compounded product that contains at least one drug or drug class that is not recommended is not recommended, the request for Cyclo/Keto 10/3% VC 20GM is not medically necessary and appropriate.