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| Case Number: | CM14-0142959 | | |
| Date Assigned: | 09/10/2014 | Date of Injury: | 05/23/2014 |
| Decision Date: | 10/14/2014 | UR Denial Date: | 08/21/2014 |
| Priority: | Standard | Application Received: | 09/03/2014 |

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 Emergency Medicine, and is licensed to practice in Texas. 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 59-year-old male with a reported date of injury on 05/23/2014. The mechanism of injury was a fall. The injured worker's diagnoses included intracranial bleed, facial trauma, closed fracture of the left radius and ulna, and right knee injury. The injured worker's past treatments included physical therapy, acupuncture, and a TENS unit. The injured worker's diagnostic testing included an MRI of the head which revealed left frontal scalp laceration with superior orbital rim/roof fractures. The injured worker's surgical history included bilateral wrist fracture repair on 05/24/2014. The subjective complaints on 07/02/2014 included headache rated 3/10. The objective physical exam findings included muscle strength to the bilateral upper and lower extremities within normal limits, intact sensory function, and all reflexes within normal limits. The injured worker's medications included Norco. The treatment plan was to continue medication and order a Functional Capacity Evaluation. A request was received for an initial Functional Capacity Evaluation and for gaba/keto/lido topical cream 240 gm. The rationale for the requests was not provided in the records. The Request for Authorization form was dated 06/31/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Initial Functional Capacity evaluation: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 5 Cornerstones of Disability Prevention and Management Page(s): 77-89. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Fitness For Duty, Functional capacity evaluation (FCE).

Decision rationale: The California MTUS/ACOEM Guidelines state Functional Capacity Evaluations may be necessary to obtain a more precise delineation of patient capabilities than is available from routine physical examination. Under some circumstances, this can best be done by ordering a functional capacity evaluation of the patient. More specifically, the Official Disability Guidelines state Functional Capacity Evaluation should be considered if there has been prior unsuccessful return to work attempts, conflicting medical reporting on precautions and/or fitness for modified job, close or at MMI/all key medical reports secured. The injured worker has chronic headaches and neck pain. There is a lack of documentation regarding if the injured worker has had prior failed attempts to return to work, conflicting medical reports or has reached maximum medical improvement. In the absence of the above information, the request is not supported by the guidelines. As such, the request is not medically necessary.

Gaba-Keto-lido topical Cream 240gm: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-112.

Decision rationale: The request for Gaba-Keto-lido topical Cream 240gm is not medically necessary. The California MTUS guidelines state that primarily recommended for neuropathic pain and any compounded product that contains at least 1 drug (or drug class) that is not recommended is not recommended. In regard to Gabapentin, it is not recommended for topical use as there is no peer-reviewed literature to support use. In regard to Ketoprofen, it is not currently FDA approved for a topical application and has an extremely high incidence of photo contact dermatitis. In regard to lidocaine, the guidelines state that there are no commercially approved topical formulations of lidocaine for neuropathic other than Lidoderm brand patches. Since the compound cream contains Gabapentin, ketoprofen, and lidocaine, it is supported. As such, the request is not medically necessary.