

Case Number:	CM14-0145316		
Date Assigned:	09/12/2014	Date of Injury:	12/14/2012
Decision Date:	10/16/2014	UR Denial Date:	08/23/2014
Priority:	Standard	Application Received:	09/08/2014

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, has a subspecialty in 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 51-year-old male who reported an injury on 12/14/2012 due to an unknown mechanism. Diagnoses were illegible. Physical examination on 05/09/2014 revealed complaints of persistent pain. Examination revealed bilateral shoulder persistent pain. Lumbar spine examination revealed the injured worker was able to touch his toes. Treatment plan was to refer for shoulder, and for the injured worker to take medications as directed. The rationale and Request for Authorization were not submitted.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retrospective: Flurbiprofen/Capsaicin/Menthol/Camphor (DOS 5/16/14): Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM, Chronic Pain Treatment Guidelines Topical Analgesics.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics, Flurbiprofen, Capsaicin, Salicylate Topicals Page(s): 111, 72, 28, 105.

Decision rationale: The retrospective request for Flurbiprofen/ Capsaicin/ Menthol/ Camphor is not medically necessary. Pertinent information may have been missed due to the handwritten note that was illegible and the poor copy quality. The California MTUS Guidelines indicate that topical analgesics are largely experimental in use with few randomized controlled trials to

determine efficacy or 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. Topical NSAIDs have been shown in meta-analysis to be superior to placebo during the first 2 weeks of treatment for osteoarthritis, but either not afterward, or with a diminishing effect over another 2 week period. This agent is not currently FDA approved for a topical application. FDA approved routes of administration for Flurbiprofen include oral tablets and ophthalmologic solution. A search of the National Library of Medicine-National Institute of Health database demonstrated no high quality human studies evaluating the safety and efficacy of this medication through dermal patches or topical administration. Capsaicin is recommended only as an option in patients who have not responded or are intolerant to other treatments. 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. The guidelines support the use of topical salicylates. The efficacy of this medication was not reported. The request does not indicate a frequency for the medication. The clinical information submitted for review does not provide evidence to justify continued use. Therefore, this request is not medically necessary.

Retrospective: Ketoprofen/ Gabapentin/Lidocaine (DOS 05/16/14): Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM, Chronic Pain Treatment Guidelines.

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

Decision rationale: The retrospective request for Ketoprofen/ Gabapentin/Lidocaine is not medically necessary. The California Medical Treatment Utilization Schedule Guidelines indicate that topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or 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. Ketoprofen is not currently FDA approved for a topical application. The guidelines indicate that topical Lidocaine (Lidoderm) may be recommended for localized peripheral pain after there has been evidence of a trial of a first line therapy (tricyclic or SNRI antidepressants or an anti-epilepsy drug such as a Gabapentin or Lyrica). No other commercially approved topical formulations of Lidocaine (whether creams, lotions, or gels) are indicated for neuropathic pain. The medical guidelines do not support the use of compounded topical analgesics. The request does not indicate a frequency for the medication. The clinical information submitted for review does not provide evidence to justify continued use. Therefore, this request is not medically necessary.