

Case Number:	CM14-0023620		
Date Assigned:	06/16/2014	Date of Injury:	03/10/2009
Decision Date:	01/05/2015	UR Denial Date:	02/24/2014
Priority:	Standard	Application Received:	02/25/2014

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 Physical Medicine and Rehabilitation and is licensed to practice in California. 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 patient is a 57-year-old female machine operator with an industrial cumulative trauma between the dates of August 2008 through June 2009. The treating physician report dated 12/16/13 indicates that the patient presents with "bilateral shoulder pain with decreased range of motion and weakness. She continues to have neck pain radiating into both upper extremities. She also continues to have pain in her right elbow as well as pain in the right hand." The physical examination findings reveal that following the initial right shoulder surgery the patient had "attempted extensive conservative management in the form of therapy, medications, and Cortisone injections." At the time of the last provided treating physician report, the patient was pending a revision right shoulder surgery. The patient had been status post rotator cuff repair surgery previously with continued internal derangement and pathology present on MR arthrogram of the right shoulder. Additionally noted by the treating physician was that an authorization was pending for 12 session of physical therapy for the lumbar spine and left shoulder. Prior treatment history includes right shoulder surgery, rotator cuff repair, but it was felt to have internal derangement per findings on magnetic resonance arthrogram of the right shoulder. MRI findings dated 10/4/13 reveal there is a high-grade multifocal partial thickness bursal surface tearing of the posterior fibers of the supraspinatus at the level of the footprint superimposed upon a background of tendinopathy. There is also mild volume loss of the supraspinatus musculature. The current diagnoses are: 1. Sprains and strains of the neck 2. Thoracic or Lumbosacral Neuritis or Radiculitis not otherwise specified 3. Olecranon Bursitis 4. Enthesopathy of the wrist

The Utilization Review (UR) report dated 2/24/14 denied the request for: Retro CYCLO/KETO 10/3% VC 120gm Date of Service 11/10/10. UR found that MTUS Chronic Pain Medical Treatment Guidelines state that neither ketoprofen nor cyclobenzaprine is recommended for topical compound formulation purposes, pages 112 and

122. This results in the entire compound's carrying an unfavorable recommendation per page 111 of the MTUS guidelines. Therefore, Retro Cyclo/Keto 10/3% VC 120gm Date of Service 9/7/10 was deemed not medically necessary by UR. The UR report dated 2/24/14 additionally denied the request for Retro CAPO 0.37% MENT 10% CAMP 2% Date of Service 11/10/10 finding that the proposed topical Capsaicin - Menthol - Camphor-containing cream was also not medically necessary nor medically appropriate. The UR denial notes that based on MTUS Chronic Pain Medical Treatment Guidelines, page 28, capsaicin is not recommended except as a last-line agent, to be considered for application in those individuals who are intolerant to and/or are unable to tolerate other medications. The UR found that in this case there was no evidence of intolerance to and/or failure of the first-line oral pharmaceuticals so as to justify usage of "largely experimental topical compounds such as the capsaicin-containing agent." Thus the request was likewise retrospectively not approved. Therefore, Retro CAPO 0.37% MENT 10% CAMP 2% Date of Service 11/10/10 was not medically necessary.

IMR ISSUES, DECISIONS AND RATIONALES

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

CAPO 0.37% MENT 10% CAMP 2%: Upheld

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

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

Decision rationale: The patient presents with "bilateral shoulder pain with decreased range of motion and weakness. She continues to have neck pain radiating into both upper extremities. She also continues to have pain in her right elbow as well as pain in the right hand." The current request is for Retro CAPO 0.37% MENT 10% CAMP 2% Date of Service 9/7/10. MTUS regarding topical analgesics states, "Largely experimental in use with few randomized controlled trials to determine efficacy or safety." In this case MTUS Chronic Pain Medical Treatment Guidelines do recommend topical NSAIDs for the treatment of peripheral joint arthritic pain. The current request for CAPO 0.37% MENT 10% CAMP 2% is not clearly defined by the treating physician and there is no way to determine the exact compounds used for this topical analgesic. MTUS states that if at least one compounded product is not recommended then the entire compound is not recommended. The current request is denied based on failure of the treating physician to clearly document the compounds used in this formulary.

RETRO: CYCLO/KETO 10/3% VC 120 GM ; 11/10/2010: Upheld

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

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

Decision rationale: The current request is for RETRO: CYCLO/KETO 10/3% VC 120 GM Date of Service 11/10/2010. The guidelines state: "Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended." The guidelines go further to specifically state that any "Non FDA-approved agents" are not recommended. In this case we find the compound included, Ketoprofen. Ketoprofen is not currently FDA approved for a topical application. Therefore any compounded product that contains Ketoprofen is not recommended per MTUS. In this case the treating physician has requested a compounded topical analgesic containing Ketoprofen. This results in the entire compound's carrying an unfavorable recommendation per the MTUS guidelines. Therefore, Retro Cyclo/Keto 10/3% VC 120gm Date of Service 11/10/10 is deemed not medically necessary. Recommendation is for denial.