

Case Number:	CM15-0011107		
Date Assigned:	01/29/2015	Date of Injury:	05/30/2004
Decision Date:	03/30/2015	UR Denial Date:	12/31/2014
Priority:	Standard	Application Received:	01/21/2015

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, Washington

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 39-year-old female who reported an injury on 05/30/2004. The mechanism of injury was not provided. Her diagnoses included lumbar sprain/strain, lumbar paraspinal muscle spasm/disc herniation, lumbar radiculitis/radiculopathy of lower extremities, and sacroiliitis of right sacroiliac joint. Past treatments included medications. On 12/08/2014, the injured worker complained of right buttock pain radiating to posterior and lateral aspect of the right thigh with numbness and tingling increasing. The injured worker described the pain as 8/10. The injured worker also reported low back pain with limited range of motion of the lumbar spine, tingling and numbness of the right leg rated at a 9/10. Physical examination revealed weakness with tingling and numbness in the right leg, and severe sacroiliac joint inflammation with signs and symptoms or radiculitis/radiculopathy to the posterior and lateral aspect of the thigh, Gaenslen's and Patrick Faber tests were positive, sacroiliac joint demonstrated severely positive on today's exam. The current medications were not specified. The treatment plan included authorization for sacroiliac joint injection, transforaminal lumbar epidural steroid injection, and medications. The request was received for Flurbiprofen 25% and capsaicin 0.025% in Lipoderm base 180gm, Gabapentin 10%, Ketoprofen 10%, Tramadol 5%, and Cyclobenzaprine 2% in Activemax base 180mg, and Terocin patches #30 with no refill. The rationale for the request was not provided. The request for authorization form was not submitted.

IMR ISSUES, DECISIONS AND RATIONALES

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

Flurbiprofen 25% and capsaicin 0.025% in Lipoderm base 180gm: Upheld

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

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

Decision rationale: The California MTUS Guidelines state that topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. The clinical information indicated that the injured worker has been utilizing the compound since at least 11/13/2014. However, there was no documentation with evidence that antidepressants and anticonvulsants were tried and failed prior to utilizing the compounded medication. In addition, the guidelines also state that any compounded product that contains at least one drug that is not recommended is not recommended. The requested compound contains flurbiprofen, which is not recommended for use on the spine, hip, or shoulder. In addition, the request as submitted did not specify the frequency of use, or the area of the body the compound is to be applied. Given the absence of the information indicated above, the request is not supported. Therefore, the request for Flurbiprofen 25% and capsaicin 0.025% in Lipoderm base 180gm is not medically necessary.

Gabapentin 10%, Ketoprofen 10%, Tramadol 5%, and Cyclobenzaprine 2% in Activemax base 180mg: Upheld

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

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

Decision rationale: The California MTUS Guidelines state that topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. The clinical information indicated that the injured worker has been utilizing the compound since at least 11/13/2014. However, there was no documentation with evidence that the use of antidepressants and anticonvulsants have been tried and failed prior to utilizing the compound. In addition, the guidelines state that any compounded product that contains at least one drug that is not recommended is not recommended. As the requested compound contains gabapentin and cyclobenzaprine, which are both not recommended for topical use, the request is not supported. In addition, the request as submitted did not specify frequency of use or the area of the body the compound is to be applied. Given the absence of the information indicated above, the request is not supported. Therefore, the request for Gabapentin 10%, Ketoprofen 10%, Tramadol 5%, and Cyclobenzaprine 2% in Activemax base 180mg is not medically necessary.

Terocin patches #30 with no refill: Upheld

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

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

Decision rationale: The California MTUS Guidelines state that topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. The clinical information indicated that the injured worker has been utilizing the Terocin patch since at least 11/13/2014. However, there was no documentation with evidence that antidepressants and anticonvulsants have been tried and failed prior to the use of the patches. Given the absence of the information indicated above, the request is not supported. In addition, the request as submitted did not specify strength of the medication or frequency of use. Therefore, the request for Terocin patches #30 with no refill is not medically necessary.