

Case Number:	CM15-0017518		
Date Assigned:	02/05/2015	Date of Injury:	05/01/1989
Decision Date:	03/30/2015	UR Denial Date:	12/29/2014
Priority:	Standard	Application Received:	01/29/2015

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, Arizona
 Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 73-year-old male who reported injury on 05/01/1989. The mechanism of injury was not provided. The documentation of 12/22/2014 revealed the injured worker had right sided low back pain radiating into his right hip and buttock, going down to the posterior right leg to the knee. The injured worker denied weakness or incontinence. The chief complaint was neck and bilateral shoulder pain. The medications included tramadol hydrochloride 50 mg tablets and Protonix DR 40 mg tablets. The prior surgeries included bilateral shoulder arthroscopy, lower extremity vein stripping, septoplasty, and bilateral knee joint replacement. The injured worker was positive for gastroesophageal reflux. The injured worker had x-rays of the lumbar spine which were noncontributory to the request. The physical examination revealed the injured worker had extension limited due to pain, but had normal flexion. The injured worker had a positive Gaenslen's on the right and a straight leg raise test that was positive on the right with back pain only. The faber test was positive, and pelvis compression test was positive on the right as well as the thrust test on the right and distraction test. The reflexes of the lower extremities for the knee jerk and ankle jerk were 0/4. Diagnoses included low back pain, lumbago, and lumbalgia. The treatment plan included nerve conduction studies, physical therapy, and chronic pain management. There was no Request for Authorization submitted for the requested medication, and there was no rationale.

IMR ISSUES, DECISIONS AND RATIONALES

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

Meds: Ket 10%, Bac 2%, Cy 2%, Gab 6%, Lid 5%, 240mg #1 x 3: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Cyclobenzaprine, Topical Analgesics, Lidocaine, Baclofen, Gabapentin, Ketoprofen Page(s): 41,.

Decision rationale: The California Medical Treatment Utilization Schedule guidelines indicates topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety 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. There is no peer-reviewed literature to support the use of topical baclofen or gabapentin. The guidelines do not recommend the topical use of Cyclobenzaprine as a topical muscle relaxants as there is no evidence for use of any other muscle relaxant as a topical product. The addition of cyclobenzaprine to other agents is not recommended. The guidelines indicate that topical lidocaine (Lidoderm) may be recommended for localized peripheral pain after there has been evidence of a trial of first-line therapy (tri-cyclic or SNRI anti-depressants or an AED such as gabapentin or Lyrica). No other commercially approved topical formulations of lidocaine (whether creams, lotions or gels) are indicated for neuropathic pain. Ketoprofen is not currently FDA approved for a topical application. There was a lack of documentation indicating the injured worker had a trial and failure of anticonvulsants and antidepressants. There was a lack of documentation of exceptional factors to warrant nonadherence to guideline recommendations. As multiple components are not recommended, this cream would not be recommended. The request as submitted failed to indicate the frequency and the body part to be treated. Additionally, there was a lack of documentation indicating a necessity for 3 refills of the medication. Given the above, the request for Meds: Ket 10%, Bac 2%, Cy 2%, Gab 6%, Lid 5%, 240 mg #1 x 3 is not medically necessary.