MAXIMUS Federal Services

Case Number:	CM13-0033860		
Date Assigned:	12/06/2013	Date of Injury:	04/06/2013
Decision Date:	01/22/2014	UR Denial Date:	10/01/2013
Priority:	Standard	Application Received:	10/10/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Physical Medicine & 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 physician 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 46-year-old male who reported an injury on 04/06/2013. The patient is currently diagnosed with a right groin hernia and small umbilical hernia as well as lumbar spine radiculopathy. The patient was seen by [redacted] on 08/06/2013. The patient reported right groin and back pain. Physical examination revealed a small umbilical bulge. Treatment recommendations were not provided. A previous Physician's Progress Report was submitted on 08/02/2013 by [redacted]. Physical examination revealed tenderness to palpation of the lumbar spine with decreased range of motion as well as a right inguinal hernia. Treatment recommendations included the continuation of current medications, chiropractic treatment and acupuncture.

IMR ISSUES, DECISIONS AND RATIONALES

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

1. Request for prescription of Flubiprofen 20 percent Cream 30gm, apply to affected area 3 times day #1: Upheld

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

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

Decision rationale: The California MTUS Guidelines state 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. Topical NSAIDs are recommended for osteoarthritis and tendonitis. There is little evidence to utilize topical NSAIDs for the treatment of osteoarthritis of the spine, hip or shoulder. The only FDA-approved topical NSAID is diclofenac, which is indicated for osteoarthritis. As per the clinical notes submitted, the patient does not maintain a diagnosis of osteoarthritis. Furthermore, there is no indication that this patient has failed a trial of oral first-line medication prior to the request for a topical analgesic. Therefore, the request is non-certified.

Tramadol 20 percent Cream, apply to affected area three times a day #1: Upheld

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

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

Decision rationale: The California MTUS Guidelines state 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. As per the clinical notes submitted, there is no indication that the patient has failed a trial of nonopioid analgesics prior to the initiation of a topical analgesic. The medical necessity has not been established. Therefore, the request is non-certified.

Cyclobenzaprine 10 percent plus Gabapentin 10 percent Cream 30gm, apply to affected area three times a day #1: Upheld

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

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

Decision rationale: The California MTUS Guidelines state 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 1 drug (or drug class) that is not recommended is not recommended as a whole. Gabapentin is not recommended, as there is no peer-reviewed literature to support its use. Other muscle relaxants are not recommended, as there is no evidence for the use of any muscle relaxant as a topical product. Based on the clinical information received and the California MTUS Guidelines, the request is non-certified.