

<b>Case Number:</b>	CM14-0005607		
<b>Date Assigned:</b>	02/03/2014	<b>Date of Injury:</b>	03/15/2002
<b>Decision Date:</b>	06/20/2014	<b>UR Denial Date:</b>	12/23/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/09/2014

### 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, has a subspecialty in Pain Medicine 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:

Prior treatment history has included physical therapy and lumbar spine epidural injections. He underwent lumbar spine surgery in 2007. His medications include the following: Naprosyn 550 mg Tizanidine 4mg, Dicol cream 305, Omeprazole 20mg, Vicodin ES, Dendracin Cream, Ambien 10 mg, Neurontin 300mg, Norco 10/325 mg. Diagnostic studies reviewed include urine toxic drugs screens which were remarkable for the detection of THC-COOH, benzoyl ecgonine, tramadol and hydroxybupropion. Progress report dated 01/14/2014 documented the patient with complaints of constant lower back pain with a rating of 6-7/10 on a numerical scale. The pain is alleviated with medications. The patient complains of occasional headache with a rating of 6-7/10. The pain is alleviated with medications. Objective findings on examination of upper extremity DTRs reveal 2\_ jaw jerk bilaterally. There is tenderness and spasm to thoracolumbar paraspinal musculature bilaterally. Range of motion of the lumbar spine reveals flexion 60 degrees, extension, right lateral flexion and left lateral flexion 20 degrees. The patient has a positive Valsalva test, Kemp test and straight leg raising test in supine position bilaterally. Motor strength is 5-/5 bilaterally. Patellar reflexes 2\_ bilaterally. UR report dated 12/23/2013 denied the request for TGHOT Cream 180 gm and Flur-Flex cream 180 gm because there is no documentation of the patient's tolerance of these or similar medications to be taken on an oral basis. The request for Lidoderm patches #30 was denied because there is no current documentation of physical exam findings indicative of radiculopathy or failed first line therapy or documented functional improvement from previous use of this topical agent

### IMR ISSUES, DECISIONS AND RATIONALES

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

**TGHOT CREAM 180GM:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines., Chapter: Topical Analg.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines, Topical Analgesics Page(s): 111-113.

**Decision rationale:** TGHot cream is a compounded topical product containing Tramadol, Gabapentin 10%, Menthol 2%, Camphor 2% and Capsaicin 0.05%. According to the Chronic Pain Medical Treatment Guidelines, topical analgesics are considered to be largely experimental in use with few randomized controlled trials to determine efficacy or safety. These products are primarily recommended for neuropathic pain when first-line measures have failed. The medical records do not establish neuropathic pain with failure of first-line measures. Capsaicin may be recommended only as an option in patients who have not responded or are intolerant to other treatments. The medical records do not substantiate there are any issues with oral medication tolerance. According to the guidelines, Gabapentin is not recommended in topical formulations. The guidelines state that any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Consequently this compounded product is not supported by the evidence based guidelines. Therefore the request is medically necessary.

**FLURFLEX CREAM 180GM:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines., Chapter: Topical Analg.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines, Topical Analgesics, page(s) 111-113. Page(s): 111-113.

**Decision rationale:** This product is a topical compound containing (NSAID) non-steroidal anti-inflammatory drugs Flurbiprofen and muscle relaxant Flexeril. The Chronic Pain Medical Treatment Guidelines state that any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. According to the guidelines, the application of any muscle relaxant in a topical formulation is not recommended, as there is no evidence for use of any muscle relaxant as a topical product. Furthermore, the guidelines outline that topical application of an NSAID, such as Flurbiprofen, may be indicated for short duration, for osteoarthritis of joints that are amenable to topical treatment. There is little evidence to utilize topical NSAIDs for treatment of the spine. Consequently, under the evidence based guidelines, neither component of this compound is recommended, and therefore is not appropriate or medically necessary.

**LIDODERM PATCHES #30 UNSPECIFIED STRENGTH.:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines : Chronic Pain Medical Treatment Guidelines., Chapter: Lidoderm® (. )

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines, Lidoderm(Lidocaine Patch), Lidoderm(Lidocaine Patch),.

**Decision rationale:** The Chronic Pain Medical Treatment Guidelines state topical Lidocaine 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). This is not a first-line treatment and is only FDA approved for post-herpetic neuralgia. The medical records do not establish this patient has an active neuropathy. The medical records do not reveal any current subjective and objective findings, nor corroborative electrodiagnostic evidence of a neuropathic pain condition, such as post-herpetic neuralgia. The medical records do not establish medical necessity. Therefore the requests for Lidoderm patches are not medically necessary.