

Case Number:	CM14-0018103		
Date Assigned:	04/16/2014	Date of Injury:	03/05/2005
Decision Date:	06/02/2014	UR Denial Date:	01/23/2014
Priority:	Standard	Application Received:	02/12/2014

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 & Rehabilitation and Pain Medicine and is licensed to practice in Texas and Ohio. 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 injured worker is a 69 year old female who reported an injury on 03/05/2004. The mechanism of injury was not provided. The clinical note submitted for review, dated 12/17/2013, stated the injured worker reported 8/10 pain to the neck, right shoulder and low back. The injured worker was reported to be taking over the counter analgesics. The physical examination reported the injured worker had painful, limited range of motion to her cervical spine, lumbar spine and shoulder. The treatment included topical creams and a home based exercise program. The request for authorization was submitted on 12/17/2013. The medication was reportedly recommended based on medically reasonable treatment requirements.

IMR ISSUES, DECISIONS AND RATIONALES

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

RETROSPECTIVE REQUEST (DOS: 12/17/13) FOR TG HOT (TRAMADOL 8%, CAMPHOR 2%, CAPSAICIN 0.05%): 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): 111-113.

Decision rationale: The retrospective request for TG Hot (Tramadol 8%, Camphor 2%, Capsaicin 0.05%) is not medically necessary. The injured worker has a history of chronic neck and back pain. The current CA MTUS Guidelines states any compounded product that contains at least one drug or drug class that is not recommended is not supported. In addition, the guidelines state there have been no studies of a 0.0375% formulation of capsaicin and there is no current indication that this increase over a 0.025% formulation would provide any further efficacy. The current medication include a formulation of 0.05% capsaciain. As the guidelines do not support the formulation of capsaicin the entire cream is not recommended. Therefore, the retrospective request for TG Hot (Tramadol 8%, Camphor 2%, Capsaicin 0.05%) is not medically necessary.

RETROSPECTIVE REQUEST (DOS: 12/17/13) FOR FLURFLEX (FLURBIPROFEN 10%, CYCLOBENZAPRINE 10%): 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): 111-113.

Decision rationale: The request for retrospective request for Flurflex (Flurbiprofen 10%, Cyclobenzaprine 10%) is not medically necessary. The injured worker has a history of chronic neck and back pain. The current CA MTUS Guidelines states any compounded product that contains at least one drug or drug class that is not recommended is not supported. In addition, the guidelines state that topical nsais may be useful for chorinc musculoskeletal pain but there are no long term studies of their effectiveness or safety. In addition, topical NSAIDs are not recommended for neuropathic pain, as there is no evidence to support their use. The guidelines also state there is no evidence for use of the muscle relaxant cyclobenzprine as a topical product. The current medication includes topical use of NSAID and muscle relaxer. Therefore, the request for retrospective request for Flurflex (Flurbiprofen 10%, Cyclobenzaprine 10%) is not medically necessary.

RETROSPECTIVE REQUEST (DOS: 12/17/13) FOR 1 PRESCRIPTION OF LIDODERM PATCHES: 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): 111-113.

Decision rationale: The retrospective request for 1 Prescription of Lidoderm Patches is not medically necessary. The injured worker has a history of chronic neck and back pain. The CA MTUS Guidelines recommend topical lidocaine may be used for localized peripheral pain after there has been evidence of a trial of first-line therapy (tricyclic or SNRI anti-depressants or an AED such as Gabapentin or Lyrica). The guidelines also states topical lidocaine, in the

formulation of a dermal patch (Lidoderm) has been designated by the FDA for neuropathic pain and further research is needed to recommend this treatment for chronic neuropathic pain disorders other than post-herpetic neuralgia. There is lack of documentation within the clinical notes submitted for review, to support the injured worker has completed a trial of first-line therapy. Therefore, the retrospective request for 1 Prescription of Lidoderm Patches is not medically necessary.