

<b>Case Number:</b>	CM14-0110783		
<b>Date Assigned:</b>	08/01/2014	<b>Date of Injury:</b>	06/13/2012
<b>Decision Date:</b>	10/24/2014	<b>UR Denial Date:</b>	06/18/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/15/2014

### 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 Management 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:

This is a female patient with the date of injury of June 13, 2012. A Utilization Review was performed on June 18, 2014 and recommended non-certification of Flurbiprofen 10%/capsaicin .023% refill 4 and Lidocaine 5% hyaluronic acid .2% refill 4. A Progress Report dated May 20, 2014 identifies Subjective Complaints of bilateral mid line low back pain and soreness and tenderness. Low back pain radiates to bilateral buttock and lower extremity right greater than left. Objective Findings identify paralumbar spasm is 2+ tenderness to palpation bilaterally. Atrophy is present in the quadriceps. Right and left resisted rotation is diminished. ROM (range of motion) of the spine is limited secondary to pain. Sensation to light touch is decreased on the right and left feet. Diagnoses identify low back pain, lumbar disc displacement, lumbar radiculopathy, and postlaminectomy syndrome of lumbar region. Treatment plan identifies Lidoderm film, 5%, applied topically.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Flurbiprofen 10% / Capsaicin .023% with 4 refills:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26 MTUS (Effective July 18, 2009) Page(s): 111-113.

**Decision rationale:** Regarding request for Flurbiprofen 10% / Capsaicin .023% with 4 refills, the requested topical compound is a combination of flurbiprofen and capsaicin. 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. Regarding the use of topical nonsteroidal anti-inflammatory, guidelines state that the efficacy in clinical trials for this treatment modality has been inconsistent and most studies are small and of short duration. Topical NSAIDs have been shown in meta-analysis to be superior to placebo during the 1st 2 weeks of treatment osteoarthritis, but either not afterwards, or with the diminishing effect over another two-week period. Regarding use of capsaicin, guidelines state that it is recommended only as an option for patients who did not respond to or are intolerant to other treatments. Within the documentation available for review, there is no indication that the patient is unable to tolerate oral NSAIDs. Oral NSAIDs have significantly more guideline support compared with topical NSAIDs. Additionally, there is no indication that the topical NSAID is going to be used for short duration. Furthermore, there is no indication that the patient has been intolerant to or did not respond to other treatments prior to the initiation of capsaicin therapy. In the absence of clarity regarding those issues, the currently requested Flurbiprofen 10% / Capsaicin .023% with 4 refills is not medically necessary.

**Lidocaine 5% / Hyaluronic Acid .2% with 4 refills:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 112.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26 MTUS (Effective July 18, 2009) Page(s): 112.

**Decision rationale:** Regarding request for Lidocaine 5% / Hyaluronic Acid .2% with 4 refills, Chronic Pain Medical Treatment Guidelines recommend the use of topical lidocaine for localized peripheral pain after there has been evidence of a trial of the 1st line therapy such as tri-cyclic antidepressants, SNRIs, or antiepileptic drugs. Guidelines go on to state that no commercially approved topical formulations of lidocaine cream, lotion, or gel are indicated for neuropathic pain. Within the documentation available for review, there is no indication that the patient has failed first-line therapy recommendations. Furthermore, guidelines do not support the use of topical hyaluronic acid. As such, the currently requested Lidocaine 5% / Hyaluronic Acid .2% with 4 refills is not medically necessary.