

Case Number:	CM14-0111846		
Date Assigned:	08/01/2014	Date of Injury:	09/17/2005
Decision Date:	09/09/2014	UR Denial Date:	06/30/2014
Priority:	Standard	Application Received:	07/17/2014

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 Anesthesiology, has a subspecialty in Pain Medicine and is licensed to practice in Texas. 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 70 year old female who had a work related injury on 09/17/05 due to an undisclosed mechanism of injury. Neither the specific injuries sustained nor the initial treatments rendered were discussed in the documents provided. The most recent medical record submitted for review is dated 04/15/14. The injured worker was complaining of persistent neck pain rated 7/10, bilateral shoulder pain rated 7/10, frequent and similar. Review of systems remains unchanged from previous visit. Physical examination cervical spine revealed decreased range of motion with flexion to 40 degrees, extension to 50 degrees, right and left lateral rotation to 70 degrees, and right and left lateral flexion to 30 degrees. There was tenderness over the paraspinal and trapezius muscles equally, positive Spurling's test bilaterally, decreased strength bilaterally at 4/5 at C5, C6, C7, and C8, normal sensation bilaterally at C5, C6, C7 and C8, and deep tendon reflexes are 2+ bilaterally in the brachial radialis and triceps. Examination of the bilateral shoulders revealed symmetrically decreased range of motion with flexion to 90 degrees, extension to 30 degrees, abduction 90 degrees, and adduction 40 degrees, internal rotation 60 degrees, and external rotation 70 degrees, positive Neer's impingement and Hawkins' impingement as well as acromioclavicular joint tenderness bilaterally, decreased strength at 4/5 of flexion and abduction. Diagnoses cervical sprain, right shoulder impingement syndrome status post arthroscopy, left shoulder impingement syndrome status post arthroscopy. Bilateral carpal tunnel syndrome per electromyogram/nerve conduction velocity dated 02/26/14. Prior utilization review was non-certified on 06/30/14.

IMR ISSUES, DECISIONS AND RATIONALES

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

Flurbiprofen/Cyclobenzaprine/Menthol cream (20%/10%/4%): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics, compounded.

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

Decision rationale: The safety and efficacy of compounded medications has not been established through rigorous clinical trials. Topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Further, California Medical Treatment Utilization Schedule, Food and Drug Administration and Official Disability Guidelines require that all components of a compounded topical medication be approved for transdermal use. This compound contains flurbiprofen and cyclobenzaprine which have not been approved for transdermal use. In addition, there is no evidence within the medical records submitted that substantiates the necessity of a transdermal versus oral route of administration. Therefore Flurbiprofen/Cyclobenzaprine/Menthol cream (20%/10%/4%) cannot be recommended as medically necessary as it does not meet established and accepted medical guidelines.

Lidoderm Patches (Lidocaine Patch 5%) #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Lidocaine (Lidoderm) Criteria for use of Lidoderm patches.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Lidoderm (lidocaine patch) Page(s): 56.

Decision rationale: As noted on page 56 of the Chronic Pain Medical Treatment Guidelines, the safety and efficacy of compounded medications has not been established through rigorous clinical trials. Lidoderm is recommended for a trial if there is evidence of localized pain that is consistent with a neuropathic etiology. There should be evidence of a trial of first-line neuropathic medications (tricyclic or serotonin norepinephrine reuptake inhibitor antidepressants or an anti-epileptic drugs such as Gabapentin or Lyrica). Lidoderm is not generally recommended for treatment of osteoarthritis or treatment of myofascial pain/trigger points. Therefore Lidoderm Patches (Lidocaine Patch 5%) #90 cannot be recommended as medically necessary as it does not meet established and accepted medical guidelines.