

Case Number:	CM14-0132774		
Date Assigned:	08/22/2014	Date of Injury:	05/02/2005
Decision Date:	09/29/2014	UR Denial Date:	07/17/2014
Priority:	Standard	Application Received:	08/19/2014

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 Oklahoma and 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 64-year-old female who reported an injury on 05/02/2005 due to cumulative trauma. On 08/05/2014 the injured worker presented with low back pain. Upon examination the injured worker walked with an antalgic right sided gait, and the ambulated with the use of a walker. There was diffuse tenderness noted over the lumbar paravertebral musculature, and moderate facet tenderness noted at the L4-S1 levels. There was a positive bilateral sacroiliac tenderness, Faber, Patrick's, sacroiliac thrust test, and Yeoman's test. There was a positive bilateral straight leg raise test. The diagnoses were lumbar disc disease, lumbar radiculopathy, lumbar facet syndrome, and bilateral sacroiliac joint arthropathy. Prior treatment included medications. The provider recommended a retrospective request of Flurbiprofen, Menthol, Lidocaine, Camphor, and Lidoderm base compounded cream. The provider's rationale was not provided. The Request for Authorization form was not included in the medical documents for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retrospective request for Flurbiprofen 25%/Menthol 5%/Lidocaine 5%/ Camphor 1%/Lipoderm base 180 grams compound cream (DOS 6/5/14 and 5/30/14): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Medicines.

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

Decision rationale: The Retrospective request for Flurbiprofen 25%/Menthol 5%/Lidocaine 5%/Camphor 1%/Lipoderm base 180 grams compound cream (DOS 6/5/14 and 5/30/14) is not medically necessary. The California MTUS Guidelines state that transdermal compounds are largely experimental in use with few randomized control trials to determine efficacy or safety. Topical analgesics are recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Any compounded product that contains at least 1 drug that is not recommended, is not recommended. The guidelines note that topical NSAIDs are recommended for osteoarthritis and tendinitis for joints amenable to topical treatment. It is recommended for short-term use. The guidelines also state that Lidoderm is the only topical formulation of Lidocaine recommended. There is lack of evidence of a failed trial of antidepressants or anticonvulsants. Additionally, the provider's request does not indicate the site at which the medication is indicated for, or the frequency in the request as submitted. As such, medical necessity has not been established.