

Case Number:	CM14-0152862		
Date Assigned:	09/23/2014	Date of Injury:	03/02/2009
Decision Date:	12/19/2014	UR Denial Date:	08/25/2014
Priority:	Standard	Application Received:	09/18/2014

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 Internal 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:

Pursuant to the clinical note dated August 15, 2014, the IW complains of low back pain with stiffness and pins and needles to the right anterior thigh. There was burning on the side of the foot. Physical examination revealed restricted range of motion with tenderness to palpation over the sacrum. A prior MRI showed degenerative joint disease at L4-L5 with right-sided disc protrusion and possible right L5 nerve root impingement. The IW has been diagnosed with low back pain; L4-L5 3 mm paracentral disc protrusion with annular tear; L3-L4 2 mm right paracentral disc protrusion; and right active L4 radiculopathy. There was multilevel neuroforaminal stenosis. Current medications include Norco 10/325mg, Tramadol 50mg, Naprosyn 500mg, Tizanidine 4mg, and Omeprazole 20mg. The provider is requesting the following transdermal cream: Flurlido-A cream (Flurbiprofen 20%/Lidocaine 5%/Amitriptyline 5%) and Ultra-Flex-G cream (Gabapentin 10%/Cyclobenzaprine 6%/Tramadol 10%). The provider also gave the IW a prescription for Gabapentin 300mg.

IMR ISSUES, DECISIONS AND RATIONALES

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

Flurlido- A Cream (Flurbiprofen20% / Lidocaine 5%/ Amitriptyline 5%) 240gm #1:
Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical analgesics Page(s): 111-113. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Section, Topical analgesics

Decision rationale: Pursuant to the Chronic Pain Medical Treatment Guidelines and the Official Disability Guidelines, Flurlido-A Cream (Flurbiprofen 20%/Lidocaine 5%/Amitriptyline 5%) 240 gm #1. Topical analgesics are largely experimental. There are few controlled trials to determine efficacy or safety. They are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Any compounded product that contains at least one drug (or drug class) that is not recommended, is not recommended. Topical Flurbiprofen is not FDA approved. No commercially approved topical formulation of lidocaine (whether creams, lotions or gels) are indicated for neuropathic pain. In this case, the treating physician requested Flurlido-A cream. Any compounded product that contains at least one drug (topical Flurbiprofen and lidocaine) is not recommended, is not recommended. Consequently, the requested Flurlido-A Cream (Flurbiprofen 20%/Lidocaine 5%/Amitriptyline 5%) 240 gm #1 is not medically necessary.

Ultraflex-G Cream (Gabapentin 10%/ Cyclobenzaprine 6% / Tramadol 10%) 240gm #1:
Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical analgesics Page(s): 111-113. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Section, Topical analgesics

Decision rationale: Pursuant to the Chronic Pain Medical Treatment Guidelines and the Official Disability Guidelines, Ultraflex-G Cream (Gabapentin 10%/ Cyclobenzaprine 6% / Tramadol 10%) 240gm #1. Topical analgesics are largely experimental few controlled trials to determine efficacy or safety. They are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Any compounded product that contains at least one drug (or drug class) that is not recommended, is not recommended. Topical Cyclobenzaprine is not recommended. Topical Gabapentin is not recommended. In this case, the treating physician requested Ultra-flex G cream. Any compounded product that contains at least one drug (topical Cyclobenzaprine and Gabapentin) that is not recommended, is not recommended. Consequently, Ultraflex-G Cream (Gabapentin 10%/ Cyclobenzaprine 6% / Tramadol 10%) 240gm #1 is not medically necessary.