MAXIMUS Federal Services

Case Number:	CM14-0177192		
Date Assigned:	10/30/2014	Date of Injury:	01/22/2014
Decision Date:	12/05/2014	UR Denial Date:	10/10/2014
Priority:	Standard	Application Received:	10/27/2014

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 Family Medicine and is licensed to practice in North Carolina. 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 patient is a 51-year-old with a reported date of injury of 01/22/2014. The patient has the diagnoses of lumbar disc displacement without myelopathy, umbilical hernia status post repair, bilateral hip sprain/strain and tear of the medial meniscus of the right knee. Per the progress notes provided by the primary treating physician dated 09/24/2014, the patient had complaints of constant severe pain in the lumbar spine, intermittent severe pain in the right knee, frequent severe pain in the bilateral hips and intermittent moderate pain in the umbilical hernia. The physical exam noted tenderness and spasm in the lumbar paraspinal muscles bilaterally with a positive Kemp's and Yeoman's tests bilaterally and a positive straight leg raise test on the right. There was 3+ tenderness in the umbilical hernia repair scar and 2+ tenderness and spasm in the bilateral hips and 3+ tenderness and spasm in the right knee anterior joint line. Treatment plan recommendations included topical analgesics and oral pain medications.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retrospective for date of service 06/11/2014, compound for Lidocaine 6%, Gabapentin 10%, Tramadol 10% 180 grams with 2 refills: 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 rationale: The California chronic pain medical treatment guidelines section on topical analgesics states:Recommended as an option as indicated below. Largely experimental in use with few randomized controlled trials to determine efficacy or safety. They are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. (Namaka, 2004) These agents are applied locally to painful areas with advantages that include lack of systemic side effects, absence of drug interactions, and no need to titrate. (Colombo, 2006) Many agents are compounded as monotherapy or in combination for pain control (including NSAIDs, opioids, capsaicin, local anesthetics, antidepressants, glutamate receptor antagonists, adrenergic receptor agonist, adenosine, cannabinoids, cholinergic receptor agonists, prostanoids, bradykinin, adenosine triphosphate, biogenic amines, and nerve growth factor). (Argoff, 2006) There is little to no research to support the use of many of these agents. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. The requested medication contains gabapentin and tramadol which are not indicated per the California MTUS for topical analgesic use. Therefore the request is not medically necessary.

Retrospective for date of service 06/11/2014, compound of Flurbiprofen 15%, Cyclobenzaprine 2%, Baclofen 2%, Lidocaine 5% 180 grams with 2 refills: 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 anlgesics Page(s): 111-113.

Decision rationale: The California chronic pain medical treatment guidelines section on topical analgesics states:Recommended as an option as indicated below. Largely experimental in use with few randomized controlled trials to determine efficacy or safety. They are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. There is little evidence to utilize topical NSAIDs for treatment of osteoarthritis of the spine, hip or shoulder. Neuropathic pain: Not recommended as there is no evidence to support use. This medication contains multiple compounds that are not recommended as topical analgesic use per the California MTUS. In addition the topical NSAID prescribed is not listed as a recommended topical NSAID per the California MTUS. Therefore the request has not met criteria as set forth in the California MTUS and is considered not medically necessary.