

Case Number:	CM14-0068497		
Date Assigned:	07/14/2014	Date of Injury:	12/13/2013
Decision Date:	12/18/2014	UR Denial Date:	04/09/2014
Priority:	Standard	Application Received:	05/13/2014

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, has a subspecialty in Pulmonary Medicine, Sleep Studies, Physical Therapy, Hyperbaric Medicine and is licensed to practice in New York. 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 49 year old male was injured at work on 12/13/2013. He was assessed by a physician on 03/03/2014. The injured worker complained of low and upper back pain and a sleep disorder. He stated that the injury is a cumulative trauma from 03/13/2013 to 12/13/2013 as a result of doing repetitive movements and excessive working habits during employment. Past medical history of a previous back injury and a gun wound surgery. On physical examination of cervical spine, tenderness was noted to palpation of the paraspinals, suboccipitals and upper trapezius muscles bilaterally. Range of motion of cervical spine was within normal limits. Lumbar spine was noted to have tenderness to palpation of the paraspinal and quadratus lumborum muscle and range of motion was decreased. Decreased pinwheel sensory dermatomes L5 through S1 on left. Left shoulder, elbow and left wrist range of motion was within normal limits. Diagnoses were lumbar spine strain/sprain, left lower extremity radiculitis, left carpal tunnel syndrome and left shoulder impingement. Treatment plans included a recommendation of chiropractic treatment, psychiatric evaluation, sleep study, TENS/Multi-Stim unit, left wrist brace, anti-inflammatory medication and continue use of previous prescribed lumbar spine brace. On follow up evaluation by physician on 04/28/2014, document states the injured worker continued to work and did not attend therapy. The physician's new recommendations were a home exercise program, diagnostic studies and transdermal anti-inflammatory and analgesic medication. On 04/09/2014 Utilization Review non-certified Capsaicin 0.0025%, Flurbiprofen 15%, Tramadol 15%, Menthol 2%, Camphor 2% QTY: 30 and 240 gram Cyclobentaprine 2%, Flurbiprofen 20% QTY: 30. This is the appeal.

IMR ISSUES, DECISIONS AND RATIONALES

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

Capsaicin 0.0025%, Flurbiprofen 15%, Tramadol 15%, Menthol 2%, Camphor 2% 240 gm Qty: 30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines topical analgesics Page(s): 111-113.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113.

Decision rationale: Per the Chronic Pain Medical Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26 MTUS (Effective July 18, 2009) page 111, topical analgesics recommended as an option as indicated below. Largely experimental in use with few randomized controlled trials to determine efficacy or safety. 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, 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 use of these compounded agents requires knowledge of the specific analgesic effect of each agent and how it will be useful for the specific therapeutic goal required. [Note: Topical analgesics work locally underneath the skin where they are applied. These do not include transdermal analgesics that are systemic agents entering the body through a transdermal means. See Duragesic (fentanyl transdermal system).] Non-steroidal antiinflammatory agents (NSAIDs): 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 first 2 weeks of treatment for osteoarthritis, but either not afterward, or with a diminishing effect over another 2-week period. (Lin, 2004) (Bjordal, 2007) (Mason, 2004). There is no evidence for use of any muscle relaxant as a topical analgesic. Menthol and camphor are not recommended. Since at least one drug product in each compound is not recommended the compound medication is not recommended. Therefore, the request is not medically necessary.