

Case Number:	CM14-0188186		
Date Assigned:	11/18/2014	Date of Injury:	04/22/2009
Decision Date:	01/07/2015	UR Denial Date:	10/28/2014
Priority:	Standard	Application Received:	11/12/2014

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:

The patient is an injured worker with a history of right knee, right elbow, and right wrist injuries. Date of injury was 04-22-2009. The progress report dated October 14, 2014 documented an evaluation of right knee, right elbow, and right wrist injuries. The patient has been deemed permanent and stationary on February 27, 2014. She has finished one series of Hyalgan injections of right knee with improvement for three months. She has had ulnar nerve neuritis for which a hinged elbow brace has been provided. The Neurontin improves numbness and tingling. The patient has a hinged elbow brace that she uses for her knee but does not use a cane. She has an elbow sleeve and soft and rigid braces for the wrist. The wrist is doing better. She does not have an elbow pad. She does use a TENS transcutaneous electrical nerve stimulation unit. Walking tolerance is no more than 45 minutes. She avoids squatting and kneeling. X-rays revealed 1 mm articular surface left along the joint line. She has sleep issues and depression. She is getting medication for sleep and depression from them. She does not drink or smoke. She has issues with sleep, stress and depression. Objective findings were documented. Her blood pressure is 111/76. Tenderness along the ulnar nerve at the elbow is noted. Hyperflexion test is equivocal. Two-point discrimination is intact. Tinel's at the elbow is noted. Tenderness along the knee is noted. Knee extension is 180 degrees and flexion is 110 degrees with no instability. Diagnoses included internal derangement of the knee on the right, ulnar nerve neuritis of the elbow on the right, epicondylitis medially on the right, and chronic pain syndrome. The patient is status post Hyalgan injection. MRI magnetic resonance imaging of the right knee showing arthritic changes and standing x-ray revealed 1-mm articular surface on the left medially and 1-mm along the patellofemoral joint. The patient uses a DonJoy brace. Elbow on the right has a negative hyperflexion test and normal two-point discrimination. There was resolution of

problems along the wrist on the right. Treatment plan included request for Tramadol, Flexeril, Protonix, Neurontin, Terocin patches, LidoPro cream, and elbow pad.

IMR ISSUES, DECISIONS AND RATIONALES

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

Flexeril 7.5 mg # 60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment Page(s): 47, 49, Chronic Pain Treatment Guidelines Cyclobenzaprine (Flexeril) , Muscle relaxants Page(s): 41-42, 63-66. Decision based on Non-MTUS Citation FDA Prescribing Information Flexeril Cyclobenzaprine <http://www.drugs.com/pro/flexeril.html>

Decision rationale: Medical Treatment Utilization Schedule (MTUS) addresses muscle relaxants. American College of Occupational and Environmental Medicine (ACOEM) 2nd Edition (2004) states that muscle relaxants seem no more effective than NSAIDs for treating patients with musculoskeletal problems, and using them in combination with NSAIDs has no demonstrated benefit. Muscle relaxants may hinder return to function by reducing the patient's motivation or ability to increase activity. Table 3-1 states that muscle relaxants are not recommended. Chronic Pain Medical Treatment Guidelines addresses muscle relaxants. Muscle relaxants should be used with caution as a second-line option for short-term treatment. Efficacy appears to diminish over time, and prolonged use of some medications in this class may lead to dependence. According to a review in American Family Physician, muscle relaxants should not be the primary drug class of choice for musculoskeletal conditions. Chronic Pain Medical Treatment Guidelines state that Cyclobenzaprine (Flexeril) is an option for a short course of therapy. Treatment should be brief. The addition of Cyclobenzaprine to other agents is not recommended. FDA guidelines state that Cyclobenzaprine is indicated for acute musculoskeletal conditions. Cyclobenzaprine should be used only for short periods (up to two or three weeks) because adequate evidence of effectiveness for more prolonged use is not available. Medical records document that the patient's occupational injuries are chronic. MTUS, ACOEM, and FDA guidelines do not support the use of Cyclobenzaprine (Flexeril) for chronic conditions. Medical records indicate the long-term use of muscle relaxants, which is not supported by MTUS guidelines. The patient has been prescribed NSAIDs. Per MTUS, using muscle relaxants in combination with NSAIDs has no demonstrated benefit. The use of Flexeril is not supported. Therefore, the request for Flexeril 7.5 mg # 60 is not medically necessary.

Lidopro Cream: 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, NSAIDs (non-steroidal anti-inflammatory drugs), Capsaicin, topical Page(s):.

Decision rationale: Medical Treatment Utilization Schedule (MTUS) Chronic Pain Medical Treatment Guidelines address topical analgesics. Topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. 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 efficacy in clinical trials of topical NSAIDs has been inconsistent and most studies are small and of short duration. Topical NSAIDs have been shown in meta-analysis to be either not superior to placebo after two weeks or with a diminishing effect after two weeks. For osteoarthritis of the knee, topical NSAID effect appeared to diminish over time. There are no long-term studies of their effectiveness or safety for chronic musculoskeletal pain. There is little evidence to utilize topical NSAIDs for treatment of osteoarthritis of the spine, hip or shoulder. Topical NSAIDs are not recommended for neuropathic pain as there is no evidence to support use. MTUS Chronic Pain Medical Treatment Guidelines addresses NSAIDs (non-steroidal anti-inflammatory drugs). All NSAIDs have the U.S. Boxed Warning for associated risk of adverse cardiovascular events, including, myocardial infarction, stroke, and new onset or worsening of pre-existing hypertension. NSAIDs can cause ulcers and bleeding in the stomach and intestines at any time during treatment. Use of NSAIDs may compromise renal function. FDA package inserts for NSAIDs recommend periodic lab monitoring of a CBC complete blood count and chemistry profile including liver and renal function tests. Routine blood pressure monitoring is recommended. It is generally recommended that the lowest effective dose be used for all NSAIDs for the shortest duration of time. Besides Lidoderm, no other commercially approved topical formulation of Lidocaine (whether creams, lotions or gels) are indicated for neuropathic pain. Further research is needed to recommend topical Lidocaine for chronic neuropathic pain disorders other than post-herpetic neuralgia. Topical Lidocaine is not recommended for non-neuropathic pain. There is only one trial that tested 4% lidocaine for treatment of chronic muscle pain. The results showed there was no superiority over placebo. Capsaicin is only an option in patients who have not responded or are intolerant to other treatments. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. LidoPro contains capsaicin, lidocaine, menthol, and methyl salicylate. Medical records indicate the long-term use of NSAIDs. Per MTUS, it is generally recommended that the lowest dose be used for NSAIDs for the shortest duration of time. Medical records document a history of GERD gastroesophageal reflux disease. Per MTUS, NSAIDs can cause ulcers and bleeding in the stomach and intestines at any time during treatment. Medical records indicate long-term NSAID use, which is not recommended by MTUS. Methyl salicylate, a component of LidoPro, is a NSAID. There is no documentation that the patient has not responded or is intolerant to other treatments. This is a requirement for the use of topical Capsaicin per MTUS. There was no documentation of post-herpetic neuralgia. Per MTUS, further research is needed to recommend topical Lidocaine for chronic neuropathic pain disorders other than post-herpetic neuralgia. Topical Lidocaine is not recommended for non-neuropathic pain. MTUS guidelines and medical records do not support the medical necessity of a topical analgesic containing Methyl Salicylate, Capsaicin, and Lidocaine, which are ingredients in LidoPro. Per MTUS guidelines, any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Therefore, the request for Lidopro Cream is not medically necessary.

