

Case Number:	CM14-0202622		
Date Assigned:	12/15/2014	Date of Injury:	08/17/2012
Decision Date:	03/30/2015	UR Denial Date:	12/03/2014
Priority:	Standard	Application Received:	12/03/2014

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: California

Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 20 year old female, who sustained an industrial injury on 08/17/2012. She has reported sitting in a chair when a co-worker pulled the chair out from under her causing her instant low back pain. Diagnoses include chronic low back pain, multilevel disc disease, lumbar four to five stenosis, lumbar five to sacral one annular tear, status post lumbar discectomy at lumbar four to five, lumbar three to four arthropathy, and rule out sacroiliac joint dysfunction. Treatment to date has included medication regimen, use of transcutaneous electrical nerve stimulation unit, use of lumbar brace, above listed surgical procedure, physical therapy, and magnetic resonance imaging. In a progress note dated 09/25/2014 the treating provider reports pain in the back and the lower extremities. The documentation provided did not contain the current requested medications. On 12/03/2014 Utilization Review non-certified the requested treatments of Flurbiprofen 20%/Lidocaine 5% 4gm and Cyclobenzaprine 10%/Lidocaine 2% 4gm, noting the California Medical Treatment Utilization Schedule, Chronic Pain Medical Treatment Guidelines, Topical Analgesics.

IMR ISSUES, DECISIONS AND RATIONALES

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

Flurbiprofen 20% Lidocaine 5% 4gm: 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 analgesic Page(s): 111-113.

Decision rationale: Based on the 08/28/14 progress report provided by treating physician, the patient presents with low back and bilateral leg pain rated 7-8/10. The request is for FLURBIPROFEN 20% LIDOCAINE 5% 4GM. The patient is status post lumbar discectomy L4-L5, 07/14/14. Patient's diagnosis on 08/28/14 included chronic low back pain, L3-L4 facet arthropathy and multilevel disc disease. Patient's medications include Norco and Motrin. The patient is not working, per treater report dated 11/20/14. Progress report with the request has not been provided. MTUS has the following regarding topical creams (p111, chronic pain section): "Topical Analgesics: 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. Topical lidocaine, in the formulation of a dermal patch (Lidoderm) has been designated for orphan status by the FDA for neuropathic pain. Lidoderm is also used off-label for diabetic neuropathy. No other commercially approved topical formulations of lidocaine (whether creams, lotions or gels) are indicated for neuropathic pain. Gabapentin: Not recommended. Baclofen: Not recommended. Other muscle relaxants: There is no evidence for use of any other muscle relaxant as a topical product." Treater has not provided reason for the request nor indicated which body part would be treated. NSAID cream is indicated for osteoarthritis, which the patient does not present with, and is to be used for short duration of 2 weeks. Also, MTUS page 111 states that if one of the compounded topical product is not recommended, then the entire product is not. In this case, the requested topical compound contains Lidocaine, which is not supported for topical use in lotion form. The request does not meet guideline criteria, therefore it IS NOT medically necessary.

Cyclobenzapren 10% Lidocaine 2% 4gm: 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 analgesic Page(s): 111-113.

Decision rationale: Based on the 08/28/14 progress report provided by treating physician, the patient presents with low back and bilateral leg pain rated 7-8/10. The request is for CYCLOBENZAPRINE 10% LIDOCAINE 2% 4GM. The patient is status post lumbar discectomy L4-L5, 07/14/14. Patient's diagnosis on 08/28/14 included chronic low back pain, L3-L4 facet arthropathy and multilevel disc disease. Patient's medications include Norco and Motrin. The patient is not working, per treater report dated 11/20/14. Progress report with the request has not been provided. MTUS has the following regarding topical creams (p111, chronic pain section): "Topical Analgesics: Non-steroidal antiinflammatory agents (NSAIDs): The

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