

Case Number:	CM14-0204845		
Date Assigned:	12/17/2014	Date of Injury:	10/13/2000
Decision Date:	02/11/2015	UR Denial Date:	11/07/2014
Priority:	Standard	Application Received:	12/08/2014

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 Physical Medicine and Rehabilitation, 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 a 55 year old female with date of injury 10/13/00. The treating physician report dated 10/10/14 (6) indicates that the patient presents with pain affecting her low back. Patient complains of aching pain in the low back rated 8/10 which goes into the bilateral lower extremities which she rates 8/10. Patient also complains of aching pain in the neck rated 9/10. The physical examination findings reveal: gait is antalgic; there is inability to heel/toe walk without weakness; the lumbar spine has well-healed incision and there is tenderness to the midline to the thoracic spine; reduced ROM with forward flexion at 15 degrees, extension at 5 degrees, and lateral flexion is 10 degrees bilaterally. There is trouble on the right leg due to recent right knee surgery and right ankle/heel pain. Prior treatment includes a nonindustrial right knee arthroscopy done five weeks prior to the 10/10/14 report. The current diagnoses are: 1. Status post lumbar fusion, L5-S12. Multilevel cervical and lumbar spine discopathy 3. Cervical sprain/strain 4. Obesity 5. Hypertension 6. Eye complaints 7. Right knee injury. The utilization review report dated 11/07/14 denied the request for two topical creams based on lack of medical necessity.

IMR ISSUES, DECISIONS AND RATIONALES

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

Lido/Gaba/Keto 6/10/10 percent cream, apply 1-2 gms to affected area 3-4 times a day:
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: The patient has low back pain. The current request is for Lido/Gaba/Keto 6/10/10 percent cream, apply 1-2 gms to affected area 3-4 times a day. The treating physician indicates that the current request is to assist the patient with inflammation (8). The MTUS has the following regarding topical creams (page 111, chronic pain section): "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." In this case Gabapentin and Lidoderm are not recommended by the MTUS guidelines. The request is not medically necessary.

Flurbi/Capsai/Menthol/Camphor 10/.005/5/5 percent cream, apply 1-2 gms to affected area 3-4 times a day: 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: The patient has low back pain. The current request is for Flurbi/Capsai/Menthol/Camphor 10/.005/5/5 percent cream, apply 1-2 gms to affected area 3-4 times a day. The treating physician indicates that the current request is for its heating/cooling effect (8). The MTUS guidelines do not support the usage of Flurbiprofen 10% cream (NSAID) for the treatment of spine, hip, shoulder or neuropathic pain. In this case there is no clear indication as to where the cream would be applied, but the patient presents with low back pain. The request is not supported by the documentation provided as required by the MTUS guidelines. The request is not medically necessary.