MAXIMUS Federal Services

Case Number:	CM15-0004184		
Date Assigned:	01/15/2015	Date of Injury:	06/06/2014
Decision Date:	03/17/2015	UR Denial Date:	12/16/2014
Priority:	Standard	Application Received:	01/08/2015

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: Pennsylvania
Certification(s)/Specialty: Internal Medicine

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 55 year old female, who sustained an industrial injury on 6/6/14. She has reported pain in the left elbow, shoulder, arm and neck. The diagnoses have included cervical disc herniation, partial tear of rotator cuff left shoulder and lateral epicondylitis of the left elbow. Treatment to date has included diagnostic studies, physical therapy, home exercise program, oral and topical medications. Initial x-rays of the left humerus, left elbow and left shoulder were negative for acute fracture. Magnetic resonance imaging of the left shoulder on 10/8/14 showed supraspinatus tendinosis, suggestion of partial subscapularis tear, degenerative change of the acromioclavicular joint, and trace joint effusion. Left shoulder surgery was recommended, but was denied by Utilization Review. As of the PR2 on 11/26/14, the injured worker is reporting sharp pain in the left shoulder, elbow and cervical spine. Examination showed spasm and tenderness in the cervical paraspinal muscles with painful range of motion, spasm and tenderness of the left rotator cuff muscles with painful range of motion and positive Codman's test, Speeds test, and supraspinatus test, and tenderness of the left lateral epicondyle. Work status was noted as modified activity in October 2014 and temporariy totally disabled (TTD) in November of 2014, with TTD status until 1/26/15. The treating physician is requesting Topical Compound: Flurbiprofen 15% Cyclobenzaprine 2 % Baclofen 2 % Lidocaine 5 % 80 Gram, Multi IF stimulator rental x 1 month, Functional Capacity evaluation and Topical Compound: Lidocaine 6 % Gabapentin 10 % Ketoprofen 10% 180 Gram. The indication for the muti interferential stimulation unit was documented to decrease pain and muscle spasm and to increase blood flow. On 12/16/14 Utilization Review (UR) non-certified a request of Topical Compound:

Flurbiprofen 15% Cyclobenzaprine 2 % Baclofen 2 % Lidocaine 5 % 80 Gram, Multi IF stimulator rental x 1 month, Functional Capacity evaluation and Topical Compound: Lidocaine 6 % Gabapentin 10 % Ketoprofen 10% 180 Gram. The UR physician cited the MTUS guidelines for chronic pain and the ODG guidelines. This Utilization Review (UR) decision was subsequently appealed to Independent Medical Review (IMR).

IMR ISSUES, DECISIONS AND RATIONALES

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

Topical Compound: Flurbiprofen 15 Percent Cyclobenzaprine 2 Percent Baclofen 2 Percent Lidocaine 5 Percent 80 Gram: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines topical analgesics Page(s): p. 111-113,Postsurgical Treatment Guidelines.

Decision rationale: Per the MTUS, topical analgesics are recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. If any compounded product contains at least one drug or drug class that is not recommended, the compounded product is not recommended. Flurbiprofen is a nonsteroidal anti-inflammatory agent (NSAID). Topical NSAIDS are indicated for osteoarthritis and tendinitis, in particular that of the knee and elbow or other joints that are amenable to topical treatment. There is little evidence to utilize topical NSAIDS for treatment of osteoarthritis of the spine, hip, or shoulder. Topical nonsteroidals are not recommended for neuropathic pain. Cyclobenzaprine is a muscle relaxant. The MTUS notes that there is no evidence for use of muscle relaxants as topical products. Baclofen is not recommended in topical form. Lidocaine is only FDA approved for treating post-herpetic neuralgia, and the dermal patch form (Lidoderm) is the only form indicated for neuropathic pain. No other commercially approved topical formulations of lidocaine (whether creams, lotions, or gels) are indicated for neuropathic pain. Non-dermal patch forms are generally indicated as local anesthetics or anti-pruritics. As multiple agents in this compound are not recommended, the compund is not recommended. The request for Topical Compound: Flurbiprofen 15 Percent Cyclobenzaprine 2 Percent Baclofen 2 Percent Lidocaine 5 Percent 80 Gram is not medically necessary.

Multi IF Stimulator Rental (Months): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines transcutaneous electrotherapy Page(s): p. 119.

Decision rationale: Per the MTUS, interferential current stimulation is not recommended as an isolated intervention. There is no quality evidence of effectiveness except in conjunction with

recommended treatments including return to work, exercise, and medications. There are no standardized protocols for the use of interferential stimulation. If certain criteria are met, a one month trial may be appropriate to permit the physician and physical medicine provider to determine effects and benefits. Criteria include pain which is ineffectively controlled by medications, history of substance abuse, pain from postoperative conditions that limit the ability to perform exercise programs, or lack of response to conservative measures. The MTUS for Chronic Pain provides very limited support for interferential treatment, notes the poor quality of medical evidence in support of interferential stimulation therapy, and states that there is insufficient evidence for using interferential stimulation for wound healing or soft tissue injury. The physician documented that the request for intereferential stimulation unit was to decrease pain and muscle spasm and to increase blood flow. The treating physician has not provided a treatment plan which includes interferential stimulation therapy in the context of the recommendations of the MTUS. This includes return to work, exercise, medications, and no conductive garment. There was no documentation of uncontrolled pain, history of substance abuse, postoperative state, or lack of response to conservative measures. The injured worker was noted to be temporarily totally disabled, which does not support prescription in accordance with the guidelines that recommend intereferential stimulation in the context of return to work. The request for Multi IF Stimulator Rental (Months) is not medically necessary.

Functional Capacity Evaluation (FCE): Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation fitness for duty chapter: functional capacity evaluation

Decision rationale: Per the ODG, functional capacity evaluation (FCE) is recommended prior to admission to a Work Hardening (WH) Program, with preference for assessments tailored to a specific task or job. FCE is not recommend for routine use as part of occupational rehab or screening, or generic assessments in which the question is whether someone can do any type of job generally. The documentation did not indicate that admission to a work hardening program was anticipated. For this reason, the request for functional capacity evaluation is not medically necessary.

Topical Compound: Lidocaine 6 Percent Gabapentin 10 Percent Ketoprofen 10 Percent 180 Gram: Upheld

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

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

Decision rationale: Per the MTUS, topical analgesics are recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. If any compounded product

contains at least one drug or drug class that is not recommended, the compounded product is not recommended. Lidocaine is only FDA approved for treating post-herpetic neuralgia, and the dermal patch form (Lidoderm) is the only form indicated for neuropathic pain. No other commercially approved topical formulations of lidocaine (whether creams, lotions, or gels) are indicated for neuropathic pain. Non-dermal patch forms are generally indicated as local anesthetics or anti-pruritics. Gabapentin is an antiepileptic drug and is not recommended in topical form; there is no peer-reviewed literature to support use. Ketoprofen, a nonsteroidal anti-inflammatory agent (NSAID), is not currently FDA approved for topical application. It has a high incidence of photocontact dermatitis. There is little evidence to utilize topical NSAIDS for treatment of osteoarthritis of the spine, hip, or shoulder, and topical NSAIDS are not recommended for neuropathic pain. As none of the agents in this compounded product are recommended, the request for Topical Compound: Lidocaine 6 Percent Gabapentin 10 Percent Ketoprofen 10 Percent 180 Gram is not medically necessary.