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| Case Number: | CM15-0185260 | | |
| Date Assigned: | 09/28/2015 | Date of Injury: | 12/08/2011 |
| Decision Date: | 11/03/2015 | UR Denial Date: | 09/01/2015 |
| Priority: | Standard | Application Received: | 09/21/2015 |

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: California

Certification(s)/Specialty: Family Practice

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 is a 35 year old male with a date of injury on 12-8-2011. A review of the medical records indicates that the injured worker is undergoing treatment for low back pain, lumbar radiculopathy, right sacroiliitis and right hip arthralgia. According to the progress report dated 8-17-2015, the injured worker complained of low back and right hip pain. He rated his low back pain as 4 to 5 out of 10. He complained of frequent muscle spasms in his right quad. He also reported numbness and tingling in his low back. Per the treating physician (8-17-2015), the injured worker was temporarily partially disabled. The physical exam (8-17-2015) revealed tenderness to palpation of the lumbar spine with spasms noted. He had decreased sensation in the right L4, L5 and S1 dermatomes. Straight leg raise was positive on the left. Treatment has included chiropractic treatment, physical therapy, transcutaneous electrical nerve stimulation (TENS) and medications. Current medications (8-17-2015) included over the counter Ibuprofen 2-3 times weekly and Flexeril cream. The request for authorization dated 8-17-2015 included Capsaicin-Cyclobenzaprine cream. The original Utilization Review (UR) (9-1-2015) denied a request for Capsaicin-Cyclobenzaprine cream.

IMR ISSUES, DECISIONS AND RATIONALES

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

Capsaicin 0.05% & Cyclobenzaprine 5% Cream: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Topical Analgesics.

Decision rationale: According to the MTUS guidelines, topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. The guidelines state that there is little to no research to support the use of many these agents. Specifically, the MTUS guidelines state that any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. The MTUS guidelines state that muscle relaxants such as cyclobenzaprine are not supported as a topical product. The guidelines with regards to capsaicin state that there is no current indication that increase over a 0.025% formulation would provide any further efficacy. The request for Capsaicin 0.05% & Cyclobenzaprine 5% Cream is not medically necessary and appropriate.