MAXIMUS Federal Services

Case Number:	CM15-0208180		
Date Assigned:	10/27/2015	Date of Injury:	05/22/2012
Decision Date:	12/08/2015	UR Denial Date:	09/24/2015
Priority:	Standard	Application Received:	10/22/2015

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, Oregon, Washington
Certification(s)/Specialty: Orthopedic Surgery

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 47 year old female, who sustained cumulative industrial trauma injuries from 05-23-2011 to 05-23-2012. A review of the medical records indicates that the worker is undergoing treatment for lumbar herniated nucleus pulposus with bilateral L5. Treatment has included Motrin. Gabapentin, Acetaminophen, Baclofen, Methocarbamol, Ketoprofen-Lidocaine cream, Flurbiprofen-Baclofen-Camphor-Menthol-Dexamethasone-Capsaicin-Hyaluronic acid cream, Flexeril, Naprosyn, physical therapy and chiropractic treatment. Subjective complaints (06-08-2015 and 07-21-2015) included neck, bilateral shoulder, bilateral wrist and low back pain rated as 7-8 out of 10. Objective findings (06-08-2015 and 07-21-2015) included facial grimacing and ability to squat with pain. The physician examination was noted to have otherwise remained the same and no further objective findings were documented. The physician noted that Flurbiprofen-Lidocaine cream and Diclofenac-Ketoprofen-Gabapentin cream were being requested to be applied to affected areas. There was no documentation of an intolerance to or failure of oral pain medications. A utilization review dated 09-24-2015 non-certified requests for Flurbiprofen 20%-Lidocaine HCI 6.15% 150g with 1 refill and Diclofenac 10%-Ketoprofen 20%-Gabapentin 10% 150g with 1 refill.

IMR ISSUES, DECISIONS AND RATIONALES

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

Flurbiprofen 20%/Lidocaine HCI 6.15% 150g with 1 refill: 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): Lidoderm (lidocaine patch), Topical Analgesics.

Decision rationale: Per the CA MTUS regarding topical analgesics, Chronic Pain Medical Treatment Guidelines, Topical analgesics, page 111-112, largely experimental in use with few randomized controlled trials to determine efficacy or safety. Primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. 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. According to CA MTUS guidelines regarding the use of topical NSAIDs the efficacy in clinical trials for this treatment modality has been inconsistent and most studies are small and of short duration. According to the CA MTUS Chronic Pain Medical Treatment Guidelines, page 56 and 57, regarding Lidocaine, may be recommended for localized peripheral pain after there has been evidence of a trial of first-line therapy (tri-cyclic or SNRI anti-depressants or an AED such as gabapentin or Lyrica). This is not a first-line treatment and is only FDA approved for post-herpetic neuralgia. Further research is needed to recommend this treatment for chronic neuropathic pain disorders other than post-herpetic neuralgia. In this case the exam note from 7/21/15 demonstrates there is no evidence of failure of first line medications such as gabapentin or Lyrica. Additionally this patient does not have a diagnosis of post-herpetic neuralgia or neuropathic pain. In this case the current request does not meet CA MTUS guidelines and therefore the request is not medically necessary.

Diclofenac 10%/Ketoprofen 20%/Gabapentin 10% 150g with 1 refill: 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: Per the CA MTUS regarding topical analgesics, Chronic Pain Medical Treatment Guidelines, Topical analgesics, page 111-112, largely experimental in use with few randomized controlled trials to determine efficacy or safety. Primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. 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. According to CA MTUS guidelines regarding the use of topical NSAIDs the efficacy in clinical trials for this treatment modality has been inconsistent and most studies are small and of short duration. According to CA MTUS guidelines the use of topical gabapentin is not recommended. There is no peer-reviewed literature to support use. In this case the current request does not meet CA MTUS guidelines and therefore the request is not medically necessary.