

<b>Case Number:</b>	CM15-0029593		
<b>Date Assigned:</b>	02/23/2015	<b>Date of Injury:</b>	08/04/1994
<b>Decision Date:</b>	04/07/2015	<b>UR Denial Date:</b>	01/28/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/18/2015

### 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, Hawaii  
 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 74-year-old female who sustained an industrial injury on 8/4/94. The injured worker reported symptoms in the shoulder and back. The diagnoses included post-laminectomy syndrome cervical and post-laminectomy syndrome thoracic region. Treatments to date include oral pain medications, oral muscle relaxant. In a progress note dated 1/2/15 the treating provider reports the injured worker was with "shoulder and radiating low back pain intermittent increased by activity decreased range of motion all plane, decreased range of motion extension, decreased range of motion flexion." On 1/26/15 Utilization Review non-certified the request for Aleveer patch #60 refill x 11 and Flurbiprofen 20%, Cyclobenzaprine 4%, Lidocaine 5% refill x 11. The MTUS, ACOEM Guidelines, (or ODG) was cited.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Aleveer patch #60 refill x 11:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Salicylate, Topical Analgesics Page(s): 105, 111-113.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics, Medications for Chronic Pain Page(s): 111-113, 60.

**Decision rationale:** The patient presents with pain affecting the shoulder accompanied by radiating low back pain. The current request is for Aleveer patch #60 refill x 11. The treating physician report dated 1/2/15 (37B) states, "Rx Aleveer patch: menthol 5% - Capsaicin 0.0375% Patch (apply 1 patch to affected area 1-2 times daily as needed. If applicable, alternate cream with patch.)" The MTUS has the following regarding the use of Capsaicin for chronic pain: "Recommended only as an option in patients who have not responded or are intolerant to other treatments. There are positive randomized studies with capsaicin cream in patients with osteoarthritis, fibromyalgia, and chronic non-specific back pain, but it should be considered experimental in very high doses. Although topical capsaicin has moderate to poor efficacy, it may be particularly useful (alone or in conjunction with other modalities) in patients whose pain has not been controlled successfully with conventional therapy." Medical reports provided do not show that the patient has previously used an Aleveer patch. There is evidence that the patient has failed other conservative treatments in the documents provided. In this case, while the request for an Aleveer patch might be medically necessary, the physician is asking for 11 refills without providing documentation of the medication's efficacy in treating the patient's symptoms. The MTUS guidelines state that a trial should be given for each individual medication and a record of pain and function with the medication should be recorded. The current request does not satisfy the MTUS guidelines as outlined on page 60. Recommendation is for denial.

**Flurbiprofen 20%, Cyclobenzaprine 4%, Lidocaine 5% refill x 11:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical analgesics Page(s): 111-113. Decision based on Non-MTUS Citation US National Institutes of health (NIH) National Library of Medicine (NLM) Pubmed, 2015, (<http://www.ncbi.nlm.nih.gov/pubmed/>).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113.

**Decision rationale:** The patient presents with pain affecting the shoulder accompanied by radiating low back pain. The current request is for Flurbiprofen 20%, Cyclobenzaprine 4%, Lidocaine 5% refill x 11. The treating physician report dated 1/2/15 (37B) provides no rationale for the current request. The MTUS guidelines have the following regarding topical analgesics: "Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended." The guidelines go on to state, "There is no evidence for use of any other muscle relaxant as a topical product." Medical reports provided, do not show that the patient has previously used this topical formulation. In this case, Cyclobenzaprine is a muscle relaxant and is not recommended as a topical product by the MTUS guidelines. Since Cyclobenzaprine is not recommended, the requested topical compound is not recommended. Furthermore, the physician is asking for 11 refills without providing documentation of the medication's efficacy in treating the patient's symptoms. The MTUS guidelines state that a trial should be given for each individual medication and a record of pain and function with the

medication should be recorded. The current request does not satisfy the MTUS guidelines as outlined on pages 60 and 111-113. Recommendation is for denial.