

<b>Case Number:</b>	CM15-0219919		
<b>Date Assigned:</b>	11/12/2015	<b>Date of Injury:</b>	05/10/2012
<b>Decision Date:</b>	12/30/2015	<b>UR Denial Date:</b>	10/12/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/09/2015

### 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, North Carolina  
 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:

The injured worker is a 62 year old male who sustained an industrial injury on 05-10-2012. A review of the medical records indicated that the injured worker is undergoing treatment for symptomatic retained lumbar hardware, right shoulder impingement syndrome and internal derangement of the bilateral hips. The injured worker is status post a lumbar fusion (no date documented). According to the treating physician's progress report on 06-22-2015, the injured worker continues to experience intermittent right sided low back pain rated at 4 out of 10, bilateral hip pain, right side greater than left side rated at 8 out of 10 and right shoulder pain rated at 8 out of 10 on the pain scale. Examination of the right shoulder demonstrated tenderness to palpation around the anterior glenohumeral area and subacromial space with positive Hawkins and impingement signs. There was reproducible symptomatology with internal rotation and forward flexion. There was no evidence of swelling or instability. The lumbar spine examination demonstrated tenderness at the right lumbar paravertebral muscles with a negative seated nerve root test. Range of motion was painful with terminal motion. Circulation, sensation and motor strength were within normal limits. There was pain and tenderness in the anterior and posterior region of the right hip and to a lesser degree on the left hip. There was posterolateral tenderness on the left side as compared to the right. Internal and external rotation of the hips reproduced symptoms. An official report of a right shoulder magnetic resonance imaging (MRI) performed on 04-28-2014 was included in the review. Prior treatments have included diagnostic testing, surgery, physical therapy and medications. Current medications as of 06-2015 were listed as Nabumetone, Tramadol ER, Cyclobenzaprine and Eszopiclone. Treatment plan consists of

continuing with therapy, medication regimen and the current request for Flurbiprofen 10%-Capsaicin 0.025% Qty: 120 and Lidocaine5%-Gabapentin 10% Qty: 60. On 10-12-2015 the Utilization Review determined the requests for Flurbiprofen 10%-Capsaicin 0.025% Qty: 120 and Lidocaine5%-Gabapentin 10% Qty: 60 were not medically necessary.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**Flurbiprofen 10%/Capsaicin 0.025% Qty: 120: 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:** CA MTUS Guidelines state that topical analgesics are largely experimental in use with few randomized controlled trials to determine safety or efficacy. There is little to no research to support the use of many of these agents. Further, a compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. The request in this case is for Flurbiprofen/Capsaicin cream. Flurbiprofen, an NSAID, is only recommended topically when oral NSAIDs are ineffective or tolerated, which is not the case in this patient. In addition, Capsaicin is only recommended when other agents have failed. Therefore, the request is not medically necessary or appropriate.

**Lidocaine5%/Gabapentin 10% Qty: 60: 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:** CA MTUS Guidelines state that topical analgesics are largely experimental in use with few randomized controlled trials to determine safety or efficacy. There is little to no research to support the use of many of these agents. Further, a compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. The request in this case is for Gabapentin/Lidocaine cream. Gabapentin is an anti-epileptic drug that is not recommended for topical use. In addition, Lidocaine is only recommended in the form of a Lidoderm patch, and is not recommended in any other form of cream, gel or lotion. Therefore, the request is not medically necessary or appropriate.