

Case Number:	CM15-0046514		
Date Assigned:	03/19/2015	Date of Injury:	12/16/2008
Decision Date:	04/20/2015	UR Denial Date:	02/27/2015
Priority:	Standard	Application Received:	03/10/2015

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: Arizona, 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:

The injured worker is a 36 year old female who sustained an industrial injury on 12/16/08. The injured worker reported symptoms in the back and lower extremities. The injured worker was diagnosed as having degeneration of lumbar or lumbosacral intervertebral disc, thoracic or lumbosacral neuritis or radiculitis unspecified, sciatic, lumbago and spondylosis of unspecified site without mention of myelopathy. Treatments to date have included non-steroidal anti-inflammatory drugs, heat application, home exercise program, aqua therapy, physical therapy, occupational therapy, chiropractic therapy, and massage therapy. Currently, the injured worker complains of lower back pain with radiation to the bilateral lower extremities. The plan of care was for medication prescriptions and a follow up appointment at a later date.

IMR ISSUES, DECISIONS AND RATIONALES

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

Compound Cream: 20% Flurbiprofen/ 5% Lidocaine, 300gm (Prescribed 02/05/2015):
Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines topical analgesics Page(s): 111-112.

Decision rationale: According to the MTUS guidelines, topical analgesics are 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. Lidocaine is 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). Lidoderm has been designated for orphan status by the FDA for neuropathic pain. Lidoderm is also used off-label for diabetic neuropathy. Flurbiprofen gel is a topical NSAID. It is indicated for relief of osteoarthritis pain in joints that lend themselves to topical treatment (ankle, elbow, foot, hand, knee, and wrist). It has not been evaluated for treatment of the spine, hip or shoulder. It is recommended for short-term use (4-12 weeks) for arthritis. In this case, the claimant does not have the above diagnoses. The claimant was receiving an epidural and other options for pain management are better supported than topical analgesics. The request for Compound Cream: 20% Flurbiprofen/ 5% Lidocaine is not medically necessary.