

Case Number:	CM14-0125553		
Date Assigned:	08/11/2014	Date of Injury:	03/31/2011
Decision Date:	10/21/2014	UR Denial Date:	07/24/2014
Priority:	Standard	Application Received:	08/05/2014

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. The expert reviewer is Board Certified in Occupational Medicine and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

Injured worker is a female with date of injury 3/31/2011. Per primary treating physician's progress report modified dated 6/18/2014, the injured worker complains of neck pain and bilateral upper extremity pain. Pain level has increased since last visit. She reports nausea and is having trouble focusing and increased pain in her neck. Quality of sleep is poor. Activity level has remained the same. Cymbalta was discontinued last visit. Lyrica was tried but not effective and causes nausea. She started physical therapy which "helps in the moment" which includes TENS and stretching. She continues to have pain 7/10 worse in her wrists, right elbow and neck. She feels her arms are getting weaker. On examination cervical range of motion is restricted with flexion limited to 25 degrees limited by pain, extension limited to 5 degrees limited by pain, right lateral bending limited to 15 degrees limited by pain, left lateral bending limited to 15 degrees limited by pain, lateral rotation to the left limited to 20 degrees limited by pain and lateral rotation to the right limited to 20 degrees limited by pain. Elbow examination reveals a medial epicondyle healed surgical scar on the left, and a medial and a lateral epicondyle healed surgical scar on the right. Tenderness to palpation is noted over the lateral epicondyle and medial epicondyle. Tinel's is positive bilateral medial epicondyles and to right dorsal wrist. Patient can make a fist with left hand. She is wearing bilateral thumb spica splints. There is pain with palpation to left first MP (metacarpal phalangeal) and IP (interphalangeal) joints. Motor testing ins limited by pain with grip 4/5 bilaterally, wrist extensors 4-/5 bilaterally, elbow flexors 4-/5 bilaterally, elbow extensors 4-/5 bilaterally. Sensation to pinprick is decreased over the C5, C6, C7, C8, T1 and worse right versus left upper extremity dermatomes. Upper extremity reflexes are 1/4 bilaterally. Diagnoses include 1) entrapment neuropathy upper limb 2) extremity pain.

IMR ISSUES, DECISIONS AND RATIONALES

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

Compound Flurbiprofen, Cyclobenzaprine 1%, Gabapentin 8%, Lidocaine 2%, Prilocaine 2%, in lamcream 8gms / day #1, REF: 5: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs section, Topical Analgesics section, Page(s): 67-73, 111-113.

Decision rationale: The MTUS Guidelines recommend the use of topical analgesics as an option for the treatment of chronic pain, however, any compounded product that contains at least one drug or drug class that is not recommended is not recommended. Topical NSAIDs, have been shown to be superior to placebo for 4-12 weeks for osteoarthritis of the knee. Topical flurbiprofen is not an FDA approved formulation. The MTUS Guidelines state that there is no evidence for use of muscle relaxants, such as cyclobenzaprine, as a topical product. The MTUS Guidelines do not recommend the use of topical gabapentin as there is no peer-reviewed literature to support use. Lidocaine is recommended for localized peripheral pain after there has been evidence of a trial of first-line therapy (tricyclic or SNRI antidepressants or an anti-epilepsy drug such as gabapentin or Lyrica). Topical lidocaine in the formulation of a dermal patch (Lidoderm) has been designated for orphan status by the FDA for neuropathic pain. Lidoderm is also used off-label for diabetic neuropathy. No other commercially approved topical formulations of lidocaine (whether creams, lotions or gels) are indicated for neuropathic pain. Non-dermal patch formulations are generally indicated as local anesthetics and anti-pruritics. In February 2007 the FDA notified consumers and healthcare professionals of the potential hazards of the use of topical lidocaine. Those at particular risk were individuals that applied large amounts of this substance over large areas, left the products on for long periods of time, or used the agent with occlusive dressings. Per the requesting physician, this compounded cream is to be applied to the injured worker's surgical scar. Cymbalta had been prescribed for neuropathic pain but was discontinued due to blurry vision and confusion. She had also failed gabapentin previously. Lyrica had been prescribed for neuropathic pain, but was discontinued because it caused nausea. She is provided a trial of Nucynta ER 50 mg twice daily, and antidepressant is to be considered in the future. Medical necessity of this request has not been established within the recommendations of the MTUS Guidelines. The request for CMPD Flurbiprofen, Cyclobenzaprine 1%, Gabapentin 8%, Lidocaine 2%, Prilocaine 2%, in lamcream 8gms / day #1, REF: 5 is determined to not be medically necessary.