

Case Number:	CM14-0145390		
Date Assigned:	09/12/2014	Date of Injury:	08/16/2011
Decision Date:	10/14/2014	UR Denial Date:	08/20/2014
Priority:	Standard	Application Received:	09/08/2014

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 Physical Medicine and Rehabilitation, has a subspecialty in Pain Medicine and is licensed to practice in California and Washington. 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:

The injured worker is a 62-year-old female with a reported date of injury on 08/16/2011. The mechanism of injury was a fall. The injured worker's diagnoses included lumbar disc herniation and lower left extremity radiculopathy. The injured worker's past treatments included pain medication. There was no relevant diagnostic imaging provided with the notes. There was no surgical history noted in the records. The subjective complaints on 07/22/2014 included low back pain rated 3/10. The objective physical exam findings noted decreased range of motion to the lumbar spine secondary to pain and a positive straight leg raise to the right lower extremity in the sitting position. The exam also noted that she had tenderness and spasms in both paraspinal musculatures. The injured worker's medications included Duexis and diclofenac/lidocaine cream. The treatment plan was to continue and refill medications. A request was received for Diclofenac/Lidocaine cream (3%/5%) 180gm and Duexis (ibuprofen/famotidine 800/26.6mg) #90. The rationale for the request was to decrease pain and inflammation. The Request for Authorization form was dated 07/28/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Diclofenac/Lidocaine cream (3%/5%) 180gm: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines

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

Decision rationale: The request for Diclofenac/Lidocaine cream (3%/5%) 180gm is not medically necessary. The California Medical Treatment Utilization Schedule (MTUS) Guidelines state that topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. The guidelines also state that any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. In regards to lidocaine, the guidelines state that there are no commercially approved topical formulations of lidocaine for neuropathic pain other than Lidoderm brand patches. Topical diclofenac is indicated for relief of osteoarthritis pain in joints that lend themselves to topical treatment. It has not been evaluated for treatment of the spine, hip, or shoulder. In addition, the submitted request does not specify the site of application. Given the above, the request is not supported. As such, the request is not medically necessary.

Duexis (ibuprofen/famotidine 800/26.6mg) #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain, Duexis® (ibuprofen & famotidine).

Decision rationale: The request for Duexis (ibuprofen/famotidine 800/26.6mg) #90 is not medically necessary. The Official Disability Guidelines state Duexis is not recommended with less benefit and higher cost, using Duexis as a first-line therapy is not justified. Duexis is indicated for rheumatoid arthritis and osteoarthritis. The injured worker has chronic back pain. The notes did not indicate if the injured worker has tried and failed other first line therapies for pain. It was noted the injured worker had been taking Duexis and reported an improvement in pain. There is no indication of significant functional improvement with the use of Duexis. Also, there was no specific rationale as to why Duexis is necessary over traditional NSAIDs and over the counter Pepcid. There is also no indication of rheumatoid arthritis or osteoarthritis, for which Duexis is indicated for. As Duexis is not supported by the guidelines, the request is not supported. As such, the request is not medically necessary.