

Case Number:	CM14-0212001		
Date Assigned:	01/02/2015	Date of Injury:	05/16/2011
Decision Date:	02/27/2015	UR Denial Date:	11/26/2014
Priority:	Standard	Application Received:	12/17/2014

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. 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

Certification(s)/Specialty: Physical Medicine & Rehabn, Pain Management

CLINICAL CASE SUMMARY

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

This is a male patient with the date of injury of May 16, 2011. A Utilization Review dated November 26, 2014 recommended non-certification of Lidocaine/Hyaluronic 6%/0.2% 120 grams date of service 10/15/14 and Flurbiprofen/Capsaicin 10%/0.025% 120 grams date of service 10/15/14. A Progress Report dated October 7, 2014 identifies Chief Complaint of lumbar back and left knee pain. Objective Findings identify limited lumbar spine range of motion. Tenderness noted over the paraspinal muscles bilaterally. Kemps test was positive bilaterally. Straight leg raise was positive at 70 degrees on the right and 60 degrees on the left with pain radiating down to the posterior thighs. Muscle strength was 4/5 in the L4, L5, and S1 nerve roots bilaterally. Sensation was decreased in the L4, L5, and S1 nerve distributions bilaterally. Decreased left knee range of motion. Valgus stress, varus stress, and patellofemoral grind tests were positive. Muscle strength was 4/5 in the left quadriceps. Diagnoses identify lumbar strain, rule out disc herniation, left knee meniscal tear status post arthroscopy, posttraumatic arthrosis of left knee, and right knee strain, rule out meniscal tear. Treatment Plan identifies dispensed medication.

IMR ISSUES, DECISIONS AND RATIONALES

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

Lidocaine/Hyaluronic (6%/0.2%) 120grams provided on date of service 10/15/14: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 9792.26 MTUS (Effective July 18, 2009), page 112. Page(s): 112.

Decision rationale: Regarding request for Lidocaine/Hyaluronic (6%/0.2%) 120grams provided on date of service 10/15/14, Chronic Pain Medical Treatment Guidelines recommend the use of topical lidocaine for localized peripheral pain after there has been evidence of a trial of the 1st line therapy such as tri-cyclic antidepressants, SNRIs, or antiepileptic drugs. Guidelines go on to state that no commercially approved topical formulations of lidocaine cream, lotion, or gel are indicated for neuropathic pain. Within the documentation available for review, there is no indication that the patient has failed first-line therapy recommendations. Furthermore, guidelines do not support the use of topical hyaluronic acid. As such, the currently requested Lidocaine/Hyaluronic (6%/0.2%) 120grams provided on date of service 10/15/14 is not medically necessary.

Flurbiprofen/Capsaicin (10%/0.025%) 120grams provided on date of service 10/15/14:
Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 9792.26 MTUS (Effective July 18, 2009) Page(s): 111-113.

Decision rationale: Regarding request for Flurbiprofen/Capsaicin (10%/0.025%) 120grams provided on date of service 10/15/14, the requested topical compound is a combination of flurbiprofen and capsaicin. Chronic Pain Medical Treatment Guidelines state that any compounded product that contains at least one drug or drug class that is not recommended, is not recommended. Regarding the use of topical nonsteroidal anti-inflammatory, guidelines state that the efficacy in clinical trials for this treatment modality has been inconsistent and most studies are small and of short duration. Topical NSAIDs have been shown in meta-analysis to be superior to placebo during the 1st 2 weeks of treatment osteoarthritis, but either not afterwards, or with the diminishing effect over another two-week period. Regarding use of capsaicin, guidelines state that it is recommended only as an option for patients who did not respond to or are intolerant to other treatments. Within the documentation available for review, there is no indication that the patient is unable to tolerate oral NSAIDs. Oral NSAIDs have significantly more guideline support compared with topical NSAIDs. Additionally, there is no indication that the topical NSAID is going to be used for short duration. Furthermore, there is no indication that the patient has been intolerant to or did not respond to other treatments prior to the initiation of capsaicin therapy. In the absence of clarity regarding those issues, the currently requested Flurbiprofen/Capsaicin (10%/0.025%) 120grams provided on date of service 10/15/14 is not medically necessary.

