

<b>Case Number:</b>	CM15-0113213		
<b>Date Assigned:</b>	06/19/2015	<b>Date of Injury:</b>	12/03/2009
<b>Decision Date:</b>	07/24/2015	<b>UR Denial Date:</b>	06/06/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/11/2015

### 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, Texas, Florida

Certification(s)/Specialty: Anesthesiology, Pain Management, Hospice & Palliative Medicine

### 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 59 year old male, who sustained an industrial injury on 12/3/09. He reported neck, bilateral shoulders, right elbow, bilateral wrists and bilateral knees. The injured worker was diagnosed as having thoracalgia, bilateral shoulder tenosynovitis, cubital tunnel syndrome of bilateral wrists, cervical spine herniated disc and lumbar spine herniated discs. Treatment to date has included total knee replacement, bilateral carpal tunnel release, oral medications including Norco, Gabapentin and Robaxin, topical Butrans patch, physical therapy, home exercise program and activity restrictions. (MRI) magnetic resonance imaging of right shoulder performed 11/6/14 revealed osteoarthropathy, partial articular supraspinatus tear, infraspinatus tendinosis, subacromial bursitis, biceps tendinosis and SLAP lesion. (MRI) magnetic resonance imaging of left shoulder, right elbow, cervical spine and lumbar spine were performed in 2010. Currently, the injured worker complains of occasional left knee pain rated 7-8/10, right wrist pain rated 7-10/10, right posterior neck pain rated 8/10, low back pain rated 8/10, bilateral shoulder pain rated 8/10 and right knee pain rated 7/10. He notes the pain is relieved by rest and medications. He is currently not working. Physical exam noted restricted range of motion of cervical spine and lumbar spine, restricted range of motion of bilateral knees; tenderness on palpation of cervical spine with hypertonicity in cervical region, tenderness in lumbar region and hypertonicity with palpation and palpation of thoracic spine revealed tenderness and hypertonicity bilaterally. The treatment plan included Flurbiprofen/lidocaine/versapro base cream, Gabapentin/amitriptyline/capsaicin/versapro and cyclobenzaprine/lidocaine/versapro.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Flurbiprofen / Lidocaine / Versapro base cream: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111-113 of 127.

**Decision rationale:** Regarding the request for Flurbiprofen/lidocaine/versapro cream, CA MTUS states that topical compound medications require guideline support for all components of the compound in order for the compound to be approved. Topical NSAIDs are indicated for Osteoarthritis and tendonitis, in particular, that of the knee and elbow or other joints that are amenable to topical treatment: Recommended for short-term use (4-12 weeks). There is little evidence to utilize topical NSAIDs for treatment of osteoarthritis of the spine, hip or shoulder. Neuropathic pain: Not recommended as there is no evidence to support use. Topical 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). Additionally, it is supported only as a dermal patch. Within the documentation available for review, none of the abovementioned criteria have been documented. Furthermore, there is no clear rationale for the use of topical medications rather than the FDA-approved oral forms for this patient, despite guideline recommendations. In light of the above issues, the currently requested Flurbiprofen/lidocaine/versapro cream is not medically necessary.

**Gabapentin / Amitriptyline / Capsaicin / Versapro base cream: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111-113 of 127.

**Decision rationale:** Regarding the request for gabapentin/amitriptyline/capsaicin/versapro cream, CA MTUS states that topical compound medications require guideline support for all components of the compound in order for the compound to be approved. Capsaicin is Recommended only as an option in patients who have not responded or are intolerant to other treatments. Regarding topical gabapentin, Chronic Pain Medical Treatment Guidelines state that topical anti-epileptic medications are not recommended. They go on to state that there is no peer-reviewed literature to support their use. Guidelines do not support the use of topical antidepressants. Within the documentation available for review, none of the abovementioned criteria have been documented. Furthermore, there is no clear rationale for the use of topical medications rather than the FDA-approved oral forms for this patient, despite guideline

recommendations. In light of the above issues, the currently requested gabapentin/amitriptyline/capsaicin/versapro cream is not medically necessary.

**Cyclobenzaprine / Lidocaine / Versapro base cream:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines

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**Decision rationale:** Regarding the request for cyclobenzaprine/lidocaine/versapro cream, CA MTUS states that topical compound medications require guideline support for all components of the compound in order for the compound to be approved. Topical 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). Additionally, it is supported only as a dermal patch. Muscle relaxants drugs are not supported by the CA MTUS for topical use. Within the documentation available for review, none of the abovementioned criteria have been documented. Furthermore, there is no clear rationale for the use of topical medications rather than the FDA-approved oral forms for this patient, despite guideline recommendations. In light of the above issues, the currently requested cyclobenzaprine/lidocaine/versapro cream is not medically necessary.