

Case Number:	CM15-0120895		
Date Assigned:	07/01/2015	Date of Injury:	03/05/2012
Decision Date:	07/30/2015	UR Denial Date:	05/20/2015
Priority:	Standard	Application Received:	06/23/2015

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

Certification(s)/Specialty: Physical Medicine & Rehabilitation, 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:

The injured worker is a(n) 30 year old female, who sustained an industrial injury on 3/5/12. She reported pain in her lower back. The injured worker was diagnosed as having lumbar discogenic disease, lumbar radiculopathy, sciatica and L4-L5 degeneration. Treatment to date has included Tylenol #3, Flexeril, Norco, an EMG/NCV study on 11/18/14, physical therapy and a lumbar MRI in 3/2014 showing a 5mm central protrusion at L4-L5 with left L5 nerve root impingement. As of the PR2 dated 4/29/15, the injured worker reports persistent lower back pain. She rates her pain a 9/10 that radiates down the left leg. Objective findings include decreased lumbar range of motion in all planes, a positive straight leg raise test on the left at 60 degrees and on the right at 50 degrees and tenderness over the midline and paraspinal musculature. The treating physician requested to start Flurbiprofen/Lidocaine cream 20%/5% 180 gm.

IMR ISSUES, DECISIONS AND RATIONALES

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

Flurbiprofen/Lidocaine cream 20%, 5% 180gm: 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 Lidocaine Page(s): 112.

Decision rationale: Regarding request for topical Flurbiprofen/lidocaine, The Chronic Pain Medical Treatment Guidelines, on pages 111-113, specify that, "any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended." 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 first line therapy such as tricyclic antidepressants, SNRIs, or antiepileptic drugs. Guidelines further stipulate 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 lidocaine preparations which are not in patch form. As such, the currently requested topical formulation which contains lidocaine is not medically necessary.