

<b>Case Number:</b>	CM15-0129235		
<b>Date Assigned:</b>	07/15/2015	<b>Date of Injury:</b>	10/13/2013
<b>Decision Date:</b>	08/11/2015	<b>UR Denial Date:</b>	06/09/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/03/2015

### 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: New Jersey, Alabama, California  
 Certification(s)/Specialty: Neurology, Neuromuscular 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 32 year old male with an industrial injury dated 10/13/2013. His diagnoses included lumbar muscle spasm, lumbar radiculopathy, lumbosacral sprain/strain, and rule out lumbar disc protrusion, right de Quervain's disease, right wrist sprain/strain, left de Quervain's disease and left wrist sprain/strain. He presented on 05/12/2015 with complaints of lower back pain described as dull and aching and rated as 7/10 without medications and 6/10 with medications. Right wrist pain was rated as 8/10 without medications and 8/10 with medications. The pain was associated with tingling and numbness to fingers. Left wrist pain was described as dull and aching pain. Physical exam noted decreased and painful range of motion of the lumbar spine. There was tenderness to palpation of the bilateral sacroiliac joints and lumbar paravertebral muscles. The right and left wrist were tender to palpation. Treatment plan included diagnostics to include MRI, medications, pain cream, hot and cold unit and urine drug screen. The treatment request for Anaprox/Naprosyn 550 mg # 60 dispensed on 05/12/2015, MRI right wrist, Prilosec/Omeprazole 20 mg # 60 dispensed on 05/12/2015 and Tramadol 37.5- 325 mg dispensed on 05/12/2015 were authorized. The treatment request for review is Flurbiprofen 10%/Gabapentin 6%/Baclofen 2%/Lidocaine 4%/Cyclobenzaprine 2% prescribed on 5/12/15, hot/cold unit and MRI of lumbar spine.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Flurbiprofen 10%/Gabapentin 6%/Baclofen 2%/Lidocaine 4%/Cyclobenzaprine 2% prescribed on 5/12/15: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113.

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

**Decision rationale:** According to MTUS, in Chronic Pain Medical Treatment guidelines section Topical Analgesics (page 111), topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. Many agents are combined to other pain medications for pain control. There is limited research to support the use of many of these agents. Furthermore, according to MTUS guidelines, any compounded product that contains at least one drug or drug class that is not recommended is not recommended. There is no documentation that all components of the prescribed topical analgesic are effective for the management of chronic pain. There is no clear evidence that the patient failed or was intolerant to first line of oral pain medications (antidepressant and anticonvulsant). Therefore, the request for Flurbiprofen 10%/Gabapentin 6%/Baclofen 2%/Lidocaine 4%/Cyclobenzaprine 2% is not medically necessary.

**Hot/Cold unit:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Cold/heat packs.  
([http://www.worklossdatainstitute.verioiponly.com/odgtwc/low\\_back.htm#SPECT](http://www.worklossdatainstitute.verioiponly.com/odgtwc/low_back.htm#SPECT)).

**Decision rationale:** According to ODG guidelines, cold therapy is "recommended as an option for acute pain at-home local applications of cold packs in first few days of acute complaint; thereafter, applications of heat packs or cold packs. (Bigos, 1999) (Airaksinen, 2003) (Bleakley, 2004) (Hubbard, 2004) Continuous low-level heat wrap therapy is superior to both acetaminophen and ibuprofen for treating low back pain. (Nadler 2003) The evidence for the application of cold treatment to low-back pain is more limited than heat therapy, with only three poor quality studies located that support its use, but studies confirm that it may be a low risk low cost option. (French-Cochrane, 2006) There is minimal evidence supporting the use of cold therapy, but heat therapy has been found to be helpful for pain reduction and return to normal function. (Kinkade, 2007) See also Heat therapy; Biofreeze cryotherapy gel". There is no evidence to support the efficacy of hot and cold therapy in this patient. There are no controlled studies supporting the use of hot/cold therapy. There is no documentation that the patient needs cold therapy. Therefore, the request for hot/Cold Unit is not medically necessary.

**MRI lumbar spine:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Special Studies and Diagnostic and Treatment Considerations Page(s): 303.

**Decision rationale:** Regarding the indications for imaging in case of back pain, MTUS guidelines stated: "Lumbar spine x rays should not be recommended in patients with low back pain in the absence of red flags for serious spinal pathology, even if the pain has persisted for at least six weeks. However, it may be appropriate when the physician believes it would aid in patient management. Unequivocal objective findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging in patients who do not respond to treatment and who would consider surgery an option. When the neurologic examination is less clear, however, further physiologic evidence of nerve dysfunction should be obtained before ordering an imaging study. Indiscriminant imaging will result in false-positive findings, such as disk bulges, that are not the source of painful symptoms and do not warrant surgery. If physiologic evidence indicates tissue insult or nerve impairment, the practitioner can discuss with a consultant the selection of an imaging test to define a potential cause (magnetic resonance imaging [MRI] for neural or other soft tissue, computer tomography [CT] for bony structures)." Furthermore, and according to MTUS guidelines, MRI is the test of choice for patients with prior back surgery, fracture or tumors that may require surgery. The patient does not have any clear evidence of new lumbar nerve root compromise. There is no clear evidence of significant change in the patient signs or symptoms suggestive of new pathology. Therefore, the request for MRI of the lumbar spine is not medically necessary.