

Case Number:	CM15-0066255		
Date Assigned:	04/14/2015	Date of Injury:	10/15/1999
Decision Date:	05/20/2015	UR Denial Date:	04/01/2015
Priority:	Standard	Application Received:	04/07/2015

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: Pennsylvania

Certification(s)/Specialty: Internal Medicine, 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 1/27/2000. Diagnoses have included cervical spondylosis without myelopathy, lumbosacral spondylosis without myelopathy and internal derangement of knee. Treatment to date has included physical therapy, transcutaneous electrical nerve stimulation (TENS), epidural steroid injections and medication. According to the progress report dated 2/5/2015, the injured worker complained of pain in his lower back radiating down to the bilateral lower extremities, right greater than left with numbness/tingling and burning sensation along the anterior and lateral aspect of the right thigh. He complained of right knee pain. He also complained of bilateral neck pain with radiation to occiput, shoulder blade and right hand. Physical exam revealed an antalgic gait. Cervical spine range of motion was restricted; muscle guarding was noted. Authorization was requested for Gabapentin 10% 30gm cream, Cyclobenzaprine 10% 30gm cream and Flurbiprofen 20% 30gm cream.

IMR ISSUES, DECISIONS AND RATIONALES

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

Gabapentin 10% 30g cream: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 112-113.

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

Decision rationale: The MTUS Guidelines strongly emphasize that any compound product that contains at least one drug or drug class that is not recommended is itself not recommended. The requested medication is a compound containing a medication in the anti-seizure class. The MTUS Guidelines do not recommend topical gabapentin because there is no literature to support its use. There was no discussion describing special circumstances that sufficiently supported this request. In the absence of such evidence, the current request for 30g of cream containing 10% gabapentin is not medically necessary.

Cyclobenzaprine 10% 30g cream: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 112-113.

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

Decision rationale: The MTUS Guidelines strongly emphasize that any compound product that contains at least one drug or drug class that is not recommended is itself not recommended. The requested medication is a compound containing a medication in the muscle relaxant class. The Guidelines do not support the use of topical muscle relaxants. There was no discussion describing special circumstances that sufficiently supported this request. In the absence of such evidence, the current request for 30g of cream containing 10% cyclobenzaprine is not medically necessary.

Flurbiprofen 20% 30g cream: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 112-113.

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

Decision rationale: The MTUS Guidelines strongly emphasize that any compound product that contains at least one drug or drug class that is not recommended is itself not recommended. The requested medication is a compound containing a medication in the non-steroidal anti-inflammatory (NSAID) class. The MTUS Guidelines recommend topical NSAIDs to treat pain due to osteoarthritis and tendonitis but not neuropathic pain. Use is restricted to several weeks because benefit decreases with time. It is specifically not recommended for use at the spine, hip, or shoulder areas. Diclofenac 1% is the medication and strength approved by the FDA. There was no discussion describing special circumstances that sufficiently supported this request. In

the absence of such evidence, the current request for 30g of cream containing 20% flurbiprofen is not medically necessary.