

Case Number:	CM15-0068964		
Date Assigned:	04/16/2015	Date of Injury:	01/30/2007
Decision Date:	05/18/2015	UR Denial Date:	03/17/2015
Priority:	Standard	Application Received:	04/11/2015

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

Certification(s)/Specialty: Emergency 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 66 year old male, who sustained an industrial injury on January 30, 2007. The injured worker has been treated for back and right knee complaints. The diagnoses have included lumbosacral neuritis, arthrodesis, lumbar post laminectomy syndrome, chronic pain syndrome, lumbar/thoracic radiculopathy, sciatica, sacroilitis, spinal enthesopathy and fasciitis. Treatment to date has included medications, radiological studies, a transcutaneous electrical nerve stimulation unit, physical therapy and lumbar surgery. Current documentation dated March 16, 2015 notes that the injured worker reported low back pain and left hip pain. He also reported bilateral arm pain, right worse than the left. The pain level was rated a four out of ten on the visual analogue scale. Objective findings were not provided. The treating physician's plan of care included a request for the retrospective creams: Flurbiprofen/Lidocaine; Gabapentin/Amitriptyline; Capsaicin and Cyclobenzaprine/Lidocaine (date of service 12/22/2015).

IMR ISSUES, DECISIONS AND RATIONALES

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

Retrospective review for the pharmacy purchase of Flurbiprofen/Lidocaine; Gabapentin/Amitriptyline; Capsaicin (compound creams for DOS 12/22/2015): 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 Analgesics Page(s): 111-113.

Decision rationale: The requested Retrospective review for the pharmacy purchase of Flurbiprofen/Lidocaine; Gabapentin/Amitriptyline; Capsaicin (compound creams for DOS 12/22/2015), is not medically necessary. California Medical Treatment Utilization Schedule (MTUS), 2009, Chronic pain, page 111-113, Topical Analgesics, do not recommend topical analgesic creams as they are considered "highly experimental without proven efficacy and only recommended for the treatment of neuropathic pain after failed first-line therapy of antidepressants and anticonvulsants". The injured worker has low back pain and left hip pain. The treating physician has not documented trials of anti-depressants or anti-convulsants. The treating physician has not documented intolerance to similar medications taken on an oral basis, nor objective evidence of functional improvement from any previous use. The criteria noted above not having been met, Retrospective review for the pharmacy purchase of Flurbiprofen/Lidocaine; Gabapentin/Amitriptyline; Capsaicin (compound creams for DOS 12/22/2015) is not medically necessary.

Retrospective Cyclobenzaprine/Lidocaine (compound creams for DOS 12/22/2015): 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): 111-113.

Decision rationale: The requested Retrospective Cyclobenzaprine/Lidocaine (compound creams for DOS 12/22/2015), is not medically necessary. California Medical Treatment Utilization Schedule (MTUS), 2009, Chronic pain, page 111-113, Topical Analgesics, do not recommend topical analgesic creams as they are considered "highly experimental without proven efficacy and only recommended for the treatment of neuropathic pain after failed first-line therapy of antidepressants and anticonvulsants". The injured worker has low back pain and left hip pain. The treating physician has not documented trials of anti-depressants or anti-convulsants. The treating physician has not documented intolerance to similar medications taken on an oral basis, nor objective evidence of functional improvement from any previous use. The criteria noted above not having been met, Retrospective Cyclobenzaprine/Lidocaine (compound creams for DOS 12/22/2015) is not medically necessary.