

<b>Case Number:</b>	CM13-0060312		
<b>Date Assigned:</b>	12/30/2013	<b>Date of Injury:</b>	04/10/2007
<b>Decision Date:</b>	04/03/2014	<b>UR Denial Date:</b>	11/22/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/03/2013

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Family Practice and is licensed to practice in Texas. 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 physician 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### 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 patient is a 46-year-old female who reported an injury on 04/10/2007. The mechanism of injury was not provided for review; however, it was noted that she had a re-injury in 2010, by way of a fall. Her initial injuries were not noted; however, the most recent clinical note dated 10/18/2013 stated that she had complaints of aching in the neck, radiating to the bilateral shoulders and upper extremities, with accompanying complaints of numbness and tingling. The patient's treatment to date is unclear; however, it was noted that she was prescribed shockwave therapy in 2013, with benefit. The patient's diagnoses include cervical discopathy, bilateral shoulder overuse tendonitis, right shoulder impingement syndrome, carpal tunnel syndrome, teres minor syndrome in the right upper extremity, status post right shoulder rotator cuff repair, and plantar arch partial tear with plantar fasciitis. It was noted that the patient was waiting for authorization for custom made orthotics for her plantar fasciitis and had recently received authorization for bilateral carpal tunnel releases. Also on this date, 10/18/2013, the patient was prescribed the topical analgesic Fluriflex; however, subsequent notes were not submitted for review detailing its efficacy. There was no other clinical information submitted for review.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Fluriflex cream (Flurbiprofen/Cyclobenzaprine): Upheld**

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

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

**Decision rationale:** California MTUS/ACOEM Guidelines recommend topical analgesics to treat neuropathic and osteoarthritic pain. Guidelines state that any compounded product containing at least 1 drug or drug class that is not recommended, deems the entire product not recommended. As Fluriflex contains flurbiprofen and cyclobenzaprine, these drugs were assessed for guideline compliance. Guidelines state that the only FDA approved topical NSAID is Voltaren gel 1%, and that topical muscle relaxants are not recommended, as there is no evidence for their use. As both of these medications included in the compounded cream Fluriflex are not recommended by guidelines, the request for Fluriflex cream (flurbiprofen/cyclobenzaprine 15%/10%) 180 grams is non-certified.