

<b>Case Number:</b>	CM14-0002249		
<b>Date Assigned:</b>	01/24/2014	<b>Date of Injury:</b>	09/30/2011
<b>Decision Date:</b>	06/24/2014	<b>UR Denial Date:</b>	12/16/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/07/2014

### 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. The expert reviewer is Board Certified in Physical Medicine and Rehabilitation and Pain Medicine, and is licensed to practice in Texas and Ohio. 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/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 injured worker is a 41-year-old female with a date of injury of 9/27/11. The mechanism of injury was not provided within the information provided for review. According to the documentation dated 1/14/14, the injured worker complained of neck pain that radiated to the right shoulder and upper part of her right arm. An MRI of the cervical spine revealed C4-5, C5-6 and C6-7 disc protrusion and right upper extremity radiculopathy. The injured worker's cervical spine range of motion demonstrated flexion and extension to 45 degrees, lateral bending bilaterally to 35 degrees, and rotation to 60 degrees bilaterally. In addition, the injured worker presented with a positive Spurling's test. The injured worker's diagnoses included cervical spine sprain/strain. The injured worker's medication regimen was not provided within the documentation available for review.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**IBUPROFEN-L 10%/5% TRANSDERM CREAM:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: CHRONIC PAIN MEDICAL TREATMENT GUIDELINES, TOPICAL ANALGESICS,

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-112.

**Decision rationale:** According to the California MTUS Guidelines, NSAIDs have been indicated for osteoarthritis and tendinitis. Topical NSAIDs are recommended for short term use (4-12 weeks). In addition, guidelines note that Lidocaine is recommended for localized peripheral pain after there has been evidence of trial of first line therapy. The guidelines note topical lidocaine is only recommended in the form of a dermal patch; no other commercially approved topical formulations of lidocaine, whether creams, lotions or gels, are indicated for neuropathic pain. The request does not specify site at which the medication is to be utilized. The provider's rationale for the request was not provided within the documentaiton. The guidelines note any compounded medication containing at least one drug or drug class that is not recommended is not recommended. As such, the request is not medically necessary.