

<b>Case Number:</b>	CM14-0016626		
<b>Date Assigned:</b>	04/11/2014	<b>Date of Injury:</b>	02/29/2012
<b>Decision Date:</b>	06/03/2014	<b>UR Denial Date:</b>	01/09/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/10/2014

### 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 Emergency Medicine and is licensed to practice in New York. 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 patient is a 52-year-old male who was injured on February 29, 2012. The patient continued to experience pain in his right hand and right shoulder. Physical examination was notable for decreased range of motion of the right shoulder, and tenderness and swelling at the base of the right middle finger. MRI (magnetic resonance imaging) of the right shoulder demonstrated a rotator cuff tear. MRI of the right hand was negative for abnormalities. The diagnoses included right hand ganglion cyst, right shoulder impingement, De Quervain's tenosynovitis, and cervical facet syndrome. The treatment included medications, topical analgesics, and surgical removal of the ganglion cyst. The request for authorization for Flurbiprofen cream 20% was submitted for consideration.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**FLURBIPROFEN CREAM 20%, 1/2 TEASPOON THREE TIMES A DAY AS NEEDED:**  
Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Section Topical Analgesics Page(s): 72,111-112.

**Decision rationale:** Flurbiprofen is a non-steroidal anti-inflammatory drug (NSAID). According to the MTUS guidelines, topical NSAIDS have been shown to be superior to placebo in the treatment of osteoarthritis, but only in the short term and not for extended treatment. The effect appears to diminish over time. Absorption of the medication can occur and may have systemic side effects comparable to oral form. Adverse effects for gastrointestinal toxicity and renal function have been reported. It has not been evaluated for treatment of the spine, hip, or shoulder. Flurbiprofen is recommended as an oral agent for the treatment of osteoarthritis and the treatment of mild to moderate pain. It is not recommended as a topical preparation. The request is not certified.