

Case Number:	CM14-0181305		
Date Assigned:	11/06/2014	Date of Injury:	07/27/2010
Decision Date:	12/11/2014	UR Denial Date:	10/21/2014
Priority:	Standard	Application Received:	10/31/2014

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 is licensed to practice in California. 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 51-year-old female who reported an injury on 07/27/2010. The mechanism of injury was not provided. Her diagnoses were noted to include displacement of cervical and lumbar intervertebral disc without myelopathy, left shoulder adhesive capsulitis, right shoulder internal derangement and of right knee osteoarthritis. Her past treatments were noted to include physical therapy, hinged knee brace, sleeve, multiple cortisone injections, a home exercise program, and medication. During assessment on 09/16/2014, the injured worker complained of right knee pain, rated 8/10, with mechanical symptoms; left shoulder pain, rated 8/10; and pain in the cervical and lumbar spines with radiating symptoms in the bilateral upper and lower extremities, rated 5/10. The physical examination of the cervical spine revealed flexion of 30 degrees, extension of 30 degrees, rotation to the right of 40 degrees, and lateral flexion to the left of 40 degrees. The physical examination of the left shoulder revealed atrophy and severe limitation of motion. The range of motion revealed flexion of 10 degrees, extension of 10 degrees, abduction of 10 degrees, adduction of 10 degrees, and internal and external rotation of 10 degrees. The range of motion in the lumbar spine was normal. His current medications were noted to include Tylenol and a topical analgesic which contained flurbiprofen 20%, cyclobenzaprine 4%, and lidocaine 5%. The treatment plan was to continue with medication and physical therapy. The rationale for the topical analgesic was to reduce pain, increase function and mobility, and decrease the need of additional oral medications. The rationale for the physical therapy was to improve strength and mobility. The Request for Authorization form was dated 09/16/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

FCL (flurbiprofen 20%, cyclobenzaprine 4%, lidocaine 5%) 180mg, qty 1.00: Upheld

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

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

Decision rationale: The request for FCL (flurbiprofen 20%, cyclobenzaprine 4%, lidocaine 5%) 180mg, qty 1.00 is not medically necessary. The California MTUS Guidelines state that topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety and are primarily recommended for neuropathic pain when trials of antidepressants or anticonvulsants have failed. The guidelines also state that any compounded product that contains at least 1 drug that is not recommended is not recommended. The requested compound cream contains flurbiprofen, cyclobenzaprine, and lidocaine. In regard to flurbiprofen, the guidelines state that topical NSAIDs may be used for arthritis and tendinitis, in particular, that of the knee and elbow or other joints that are amenable to topical treatment for short term use (4 weeks to 12 weeks). There is little evidence to utilize topical NSAIDs for treatment of osteoarthritis of the spine, hip, or shoulder. The use of topical NSAIDs is not recommended for neuropathic pain as there is no evidence to support the use. Topical cyclobenzaprine is not recommended for use as there is no evidence for use of any other muscle relaxant as a topical product. In regard to lidocaine, the guidelines state that use of this product is only recommended in a formulation of the brand Lidoderm patch for neuropathic pain at this time. There was a lack of adequate documentation regarding failure of antidepressants and anticonvulsants. Additionally, the application site for the proposed medication was also not provided. Moreover, as the compound contains one or more drugs that are not recommended by the guidelines at this time, the compound is also not supported. Additionally, the request, as submitted, failed to indicate a frequency of use. Given the above, the request is not medically necessary.

Physical Therapy for cervical, left shoulder, lumbar right knee: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99.

Decision rationale: The request for Physical Therapy for cervical, left shoulder, lumbar right knee is not medically necessary. According to the California MTUS Guidelines, up to 10 visits of physical therapy is recommended for patients with unspecified radiculitis or myalgia to promote functional improvement and provide instruction in a home exercise program. There was a lack of documentation indicating whether the injured worker had physical therapy previously with documentation including the number of sessions completed and evidence of significant

objective functional improvement with any other prior physical therapy. Furthermore, the request for physical therapy did not indicate the number of visits. Due to the lack of pertinent information, the request for Physical Therapy for cervical, left shoulder, lumbar right knee is not medically necessary.