

<b>Case Number:</b>	CM14-0038817		
<b>Date Assigned:</b>	06/27/2014	<b>Date of Injury:</b>	10/14/2005
<b>Decision Date:</b>	08/15/2014	<b>UR Denial Date:</b>	03/11/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/02/2014

### 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 & Rehab and is licensed to practice in Nevada. 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 records presented for review indicate that this 47 year-old individual was reportedly injured on 10/14/2005. The mechanism of injury is noted as a motor vehicle. The most recent progress note, dated 3/3/2014 indicates that there are ongoing complaints of low back pain that radiates down into the right lower extremity. The physical examination demonstrated lumbar/sacral spine: positive tenderness to palpation and muscle spasms that paraspinal musculature. Right lower extremity muscle weakness 4/5. Diagnostic imaging studies mentioned a lumbar spine MRI dated 1/24/2014 which reveals satisfactory postop changes at L5-S1. Moderate right greater than left foraminal stenosis based on facet hypertrophy. Official radiological report are available for review. Previous treatment includes previous surgery, physical therapy, medications, and conservative treatment. A request had been made for Flurbiprofen 20% Gel 120gm and was not certified in the pre-authorization process on 3/11/2014.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Flurbiprofen 20% Gel 120gm:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111-113 of 127.

**Decision rationale:** Recommended as an option as indicated below. Largely experimental in use with few randomized controlled trials to determine efficacy or safety. Primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. These agents are applied locally to painful areas with advantages that include lack of systemic side effects, absence of drug interactions, and no need to titrate. After review of the medical documentation provided was unable to identify any failure of a first-line treatment options to include antidepressants/anticonvulsants. Therefore, this request is deemed not medically necessary.