

<b>Case Number:</b>	CM14-0198636		
<b>Date Assigned:</b>	12/08/2014	<b>Date of Injury:</b>	10/12/2012
<b>Decision Date:</b>	01/23/2015	<b>UR Denial Date:</b>	11/08/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/25/2014

### 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 Wisconsin. 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 61 year old male who reported an injury on 10/12/2012. The mechanism of injury was not included in the documentation submitted for review. His diagnosis was noted as lumbar facet arthropathy, chronic pain trauma, and status post right wrist fracture. His current medications were noted to include ASA, Hydrocodone-acetaminophen and ibuprofen. A physician's report dated 3/28/14 noted the injured worker had complaints of low back pain that did not radiate to the lower extremities. He rated his pain at a 2/10 with medication, and 4-8/10 without medication, and stated his pain had greatly improved since his last visit. The injured worker reported excellent functional improvement mobility. The lumbar spine examination revealed tenderness upon palpation bilaterally in the paravertebral area at L4-S1 levels. The range of motion of the Lumbar spine showed decreased flexion limited to 40 degrees and extension limited to 15 degrees due to pain. Facet signs were present bilaterally at L4-S1. The sensory examination was within normal limits. The motor examination was within normal limits in bilateral lower extremities. Achilles and patellar reflexes were within normal limits bilaterally and the straight leg raise at 90 degrees in a sitting position was noted to be negative bilaterally. A MRI of the lumbar spine was performed on 12/08/2012 which was noted to show mild degenerative disc disease. The treatment included the providers recommendations of continuation of medication and new medications prescribed. The rationale for the requested service and request for authorization was not included in the documentation 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 240gm:** 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:** The request for Fluriflex cream 240gm is not medically necessary. The California MTUS Guidelines state that use of a compound agent, like the one requested item, requires knowledge of the specific analgesic effect of each agent, and how it would be useful for the specific therapeutic goal required. Additionally, the references to the component medication cyclobenzaprine, this guideline states there is no evidence for use of muscle relaxants as a topical product. There are no documented failed attempts with first line treatment of antidepressants and anticonvulsants prior to the use of the requested topical analgesic. Furthermore, the request submitted failed to include frequency and duration as well as the location in which the topical cream would be used for. For these reasons, the guidelines do not support the use of this topical agent. As such, the request for Fluriflex cream 240gm is not medically necessary.

**TG hot cream 240gm:** 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:** The California MTUS Guidelines state that use of a compounded agent requires knowledge of the specific analgesic effect of each, and how it would be useful for the specific therapeutic goal required. The medical records submitted for review do not provide such detail to support the rationale for this request. Additionally, regarding the component medication gabapentin, the same guideline states that gabapentin is not recommended for topical use. There is no peer reviewed literature to support its use. There are no documented failed attempts with first line treatment of antidepressants and anticonvulsants prior to the use of the requested topical analgesic. Additionally, the same guideline does not support capsaicin at a concentration over 0.025%. Furthermore, the request submitted for review failed to include the location and frequency in which the topical cream was going to be used. For these reasons, the request is not medically necessary. As such, the request for TG hot cream 240gm is not medically necessary.