

<b>Case Number:</b>	CM15-0133381		
<b>Date Assigned:</b>	07/21/2015	<b>Date of Injury:</b>	05/31/2013
<b>Decision Date:</b>	08/17/2015	<b>UR Denial Date:</b>	06/18/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/09/2015

### 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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: Massachusetts

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Pain Management

### 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 46 year old male with an industrial injury dated 05/31/2013. The injury is documented as occurring when he was carrying a refrigerator with a coworker resulting in pain in the lumbar spine. His diagnoses included lumbar sacral spondylotic changes, lumbar sacral spinal canal stenosis, lumbar sacral annular tear and lumbar disc protrusion. Prior treatment included diagnostics, medial branch nerve block, physical therapy, chiropractic care, TENS, electrostimulation and medications. The injured worker presented on 05/29/2015 with complaints of low back pain radiating to the buttocks and leg. The pain is rated as 9-10/10. Objective findings document no change in lumbar spine since last visit. Range of motion was decreased and sitting straight leg raise was negative. The treatment request is for Flurbiprofen 20%/Baclofen 10%/Dexamethasone 2% in cream base quantity unspecified.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Flurbiprofen 20%/Baclofen 10%/Dexamethasone 2% in cream base quantity unspecified:**  
Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines (1) Medications for chronic pain, p60 (2) Topical Analgesics, p111-113.

**Decision rationale:** The claimant sustained a work injury in May 2013 and continues to be treated for radiating back pain. When seen, there was decreased lumbar spine range of motion. Kemp's testing was positive. His BMI was 26.6. Medications were refilled including Flector and topical compounded cream. This request is for a compounded topical medication with components including, Flurbiprofen and baclofen. Compounded topical preparations of flurbiprofen are used off-label (non-FDA approved) and have not been shown to be superior to commercially available topical medications such as diclofenac. Topical diclofenac in a patch form (Flector) is also being prescribed which is duplicative. Baclofen is a muscle relaxant and there is no evidence for the use of any muscle relaxant as a topical product. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. By prescribing a compounded medication, in addition to increased risk of adverse side effects, it is not possible to determine whether any derived benefit is due to a particular component. This medication is not medically necessary.