MAXIMUS Federal Services

Case Number:	CM15-0135022		
Date Assigned:	07/23/2015	Date of Injury:	04/17/2014
Decision Date:	08/19/2015	UR Denial Date:	07/01/2015
Priority:	Standard	Application Received:	07/13/2015

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: California
Certification(s)/Specialty: Emergency Medicine

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 56-year-old male who sustained an industrial /work injury on 4/17/14. He reported an initial complaint of low back and knee pain. The injured worker was diagnosed as having acute cervical strain, lumbar strain, left shoulder rotator cuff syndrome, bilateral knee osteoarthritis, and left S1 nerve root impingement at L5-S1. Treatment to date includes medication. Currently, the injured worker complained of persistent neck rated 5/10, lower back pain rated 7/10, left shoulder pain rated 4/10, and right knee pain rated 7-8/10. Per the primary physician's report (PR-2) on 6/20/15, exam of the lumbar spine revealed tenderness in the midline, asymmetric loss of range of motion, positive straight leg raise in a sitting position. Exam of the right knee revealed varus alignment, crepitus on passive range of motion, medial and lateral joint line tenderness, range of motion 0-90 degrees, antalgic gait, gait favoring the left lower extremity, and neurologically intact. The requested treatments include Flurbiprofen / Baclofen / Lidocaine cream (20%/5%/4%) 180gm.

IMR ISSUES, DECISIONS AND RATIONALES

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

Flurbiprofen/Baclofen/Lidocaine cream (20%/5%/4%) 180gm: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical analgesics. Decision based on Non-MTUS Citation ACOEM, Analgesic Creams, ODG Topical compound.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines page 111-113, Topical Analgesics Page(s): 111-113.

Decision rationale: The requested Flurbiprofen/Baclofen/Lidocaine cream (20%/5%/4%) 180gm, is not medically necessary. California Medical Treatment Utilization Schedule (MTUS), 2009, Chronic pain, page 111-113, Topical Analgesics, do not recommend topical analgesic creams as they are considered "highly experimental without proven efficacy and only recommended for the treatment of neuropathic pain after failed first-line therapy of antidepressants and anticonvulsants." The injured worker has persistent neck rated 5/10, lower back pain rated 7/10, left shoulder pain rated 4/10, and right knee pain rated 7-8/10. Per the primary physician's report (PR-2) on 6/20/15, exam of the lumbar spine revealed tenderness in the midline, asymmetric loss of range of motion, positive straight leg raise in a sitting position. Exam of the right knee revealed varus alignment, crepitus on passive range of motion, medial and lateral joint line tenderness, range of motion 0-90 degrees, antalgic gait, gait favoring the left lower extremity, and neurologically intact. The treating physician has not documented trials of anti-depressants or anti-convulsants. The treating physician has not documented intolerance to similar medications taken on an oral basis, nor objective evidence of functional improvement from any previous use. The criteria noted above not having been met, Flurbiprofen / Baclofen / Lidocaine cream (20%/5%/4%) 180gm is not medically necessary.