

<b>Case Number:</b>	CM15-0187079		
<b>Date Assigned:</b>	09/29/2015	<b>Date of Injury:</b>	05/03/2015
<b>Decision Date:</b>	11/18/2015	<b>UR Denial Date:</b>	09/10/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/23/2015

### 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: Pennsylvania, Ohio, California  
 Certification(s)/Specialty: Physical Medicine & Rehabilitation

### 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, who sustained an industrial injury on 5-3-2015. He reported injury to the right shoulder and low back from attempting to assist when someone else was falling. A right shoulder MRI dated 6-2-15, noted on evaluation 7-9-15, to be significant for full thickness rotator cuff tear. Diagnoses include right shoulder impingement and rupture of right rotator cuff and lumbar strain. Treatments to date include activity modification and Ibuprofen. Currently, he complained of pain in the right shoulder and low back rated 5 out of 10 VAS. On 7-9-15, the physical examination documented tenderness and muscle spasm noted over paralumbar region. There was tenderness and weakness to right upper extremity with positive Hawkins and Neer impingement tests. The plan of care included ice treatments and oral ibuprofen. The records indicated he was pending authorization for a right shoulder rotator cuff repair. This appeal requested retrospective authorization of Flurbiprofen 20% 30 grams; Gabapentin 10% 30 gram; and Cyclobenzaprine 10% cream from date of service 8-11-15. The Utilization Review dated 9-10-15, denied these requests.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Retrospective review of Flurbiprofen 20%, 30gm cream, QTY: 1: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Topical Analgesics.

**Decision rationale:** MTUS recommends the use of compounded topical analgesics only if there is documentation of the specific proposed analgesic effect and how it will be useful for the specific therapeutic goal required. The records in this case do not provide such a rationale for this topical medication or its ingredients. Moreover, topical NSAIDs are indicated per this guideline at most for 2-3 weeks in the acute phase of an injury. This request is not medically necessary.

**Retrospective review of Gabapentin 10%, 30gm cream, QTY: 1: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Topical Analgesics.

**Decision rationale:** MTUS recommends the use of compounded topical analgesics only if there is documentation of the specific proposed analgesic effect and how it will be useful for the specific therapeutic goal required. The records in this case do not provide such a rationale for this topical medication or its ingredients. Moreover MTUS specifically does not recommend Gabapentin for topical use. This request is not medically necessary.

**Retrospective review of Cyclobenzaprine 10%, 30gm cream, QTY: 1: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Topical Analgesics.

**Decision rationale:** MTUS recommends the use of compounded topical analgesics only if there is documentation of the specific proposed analgesic effect and how it will be useful for the specific therapeutic goal required. The records in this case do not provide such a rationale for this topical medication or its ingredients. Moreover MTUS specifically does not recommend cyclobenzaprine for topical use. This request is not medically necessary.