

Case Number:	CM15-0048094		
Date Assigned:	03/20/2015	Date of Injury:	02/01/2002
Decision Date:	05/01/2015	UR Denial Date:	02/25/2015
Priority:	Standard	Application Received:	03/13/2015

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: New York, Tennessee
 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 54 year old female, who sustained an industrial injury on February 1, 2002. The injured worker was diagnosed as having overuse syndrome bilateral upper extremity, bilateral tendinitis shoulder, epicondylitis left elbow, cubital and carpal tunnel syndrome, De Quervain's tendinitis, trigger finger and carpal tunnel release left wrist. Treatment and diagnostic studies to date have included medication and physical therapy. A progress note dated January 13, 2015 the injured worker complains of bilateral shoulder, elbow, and wrist pain. Physical exam notes shoulder tenderness and finger spasm. The plan includes oral and topical medication, ice, wrist braces and ice.

IMR ISSUES, DECISIONS AND RATIONALES

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

Flurbiprofen/Lidocaine cream 20%-5% 180gm, times three (3) refills: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Pain Interventions and Guidelines Page(s): 111-112.

Decision rationale: This medication is a compounded topical analgesic containing flurbiprofen and lidocaine. Topical analgesics are recommended for neuropathic pain when anticonvulsants and antidepressants have failed. Compounded topical analgesics are commonly prescribed and there is little to no research to support the use of these compounds. Furthermore, the guidelines state that "Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended." Flurbiprofen is a non-steroidal anti-inflammatory drug (NSAID). Flurbiprofen is recommended as an oral agent for the treatment of osteoarthritis and the treatment of mild to moderate pain. It is not recommended as a topical preparation. Lidocaine is recommended for localized peripheral pain after the evidence of a trial for first-line therapy, such as an antidepressant or antiepileptic drug. It is only FDA approved for the treatment of post-herpetic neuralgia. In this case, there is no documentation that the patient has failed treatment with first line therapies. Lidocaine is not recommended. The guidelines state that further research is needed to recommend this treatment for chronic neuropathic pain. This medication contains drugs that are not recommended. Therefore, the medication cannot be recommended. The request is not medically necessary.