

<b>Case Number:</b>	CM14-0115385		
<b>Date Assigned:</b>	09/16/2014	<b>Date of Injury:</b>	08/31/1996
<b>Decision Date:</b>	11/19/2014	<b>UR Denial Date:</b>	07/07/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/22/2014

### 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 Physical Medicine and Rehabilitation and is licensed to practice in California. 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 58-year-old female who sustained an injury on 8/31/96. On 5/20/14, she complained of pain in her back radiating into her right lower extremity. On 4/29/14, she complained of extreme pain in the low back and both legs. She indicated that her pain with medications was 9/10 and without medications was 10/10 indicating minimum improvement with medications. It was felt that she would be a candidate for possible kyphoplasty or vertebroplasty for compression fracture of lumbar spine. It was not clear when compression fracture of the lumbar spine occurred. UDS dated 09/08/14 was positive for oxazepam, nordiazepam, temazepam, and hydromorphone. Current medications include Valium, dilaudid, Celebrex, Prilosec, Pristiq, Centraline, and Fluroflex. There are no patient reports to review. Previous utilization review letters were used to get this information. The request for 1 Flouroflex ointment to apply to affected site three times daily, qty:240 grams, duration of two months, refills: none listed, for submitted diagnosis of neuropathic pain related to lower back injury as an outpatient between 07/03/14 and 09/01/14 was denied on 07/07/14.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Flouroflex ointment to apply to affected site three times daily, qty:240 grams, duration of two months for submitted diagnosis of neuropathic pain related to lower back injury as an outpatient:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines topical analgesics Page(s): 111.

**Decision rationale:** Per guidelines, topical analgesics are recommended as an option, applied locally to painful areas with advantages that include lack of systemic side effects, absence of drug interactions, and no need to titrate. They are largely experimental in use with few randomized controlled trials to determine efficacy or safety and primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. There is little to no research to support the use of many of these agents. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. The use of these compounded agents requires knowledge of the specific analgesic effect of each agent and how it will be useful for the specific therapeutic goal required. In this case, there is no information as to the ingredients in the requested compounded cream. As such, the request is considered not medically necessary according to guidelines.