

<b>Case Number:</b>	CM14-0120444		
<b>Date Assigned:</b>	08/06/2014	<b>Date of Injury:</b>	12/12/2006
<b>Decision Date:</b>	09/10/2014	<b>UR Denial Date:</b>	07/02/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/28/2014

### 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 Anesthesiology, has a subspecialty in Pain Medicine and is licensed to practice in Texas. 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 47 year old female who had a reported date of injury as 12/12/06. No clinical documentation of mechanism of injury. Most recent clinical documentation submitted for review dated 06/30/14 was a handwritten note and difficult to read. The injured worker complained of pain in her lumbosacral spine status post fusion. The injured worker fell in her tub and now felt pain over her right sacroiliac joint. This is now worse. Physical examination; lumbosacral well healed incision, positive tenderness over the right sacroiliac joints, left greater than right. Positive Faber, Patrick test. Decreased range of motion, secondary to pain. Decreased sensation over the left S1 dermatome. Diagnosis; Herniated disc lumbosacral spine. Lumbar radiculitis/neuritis. Post-operative. Prior utilization review on 06/30/14 was not medically necessary.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Flurbiprofen sodium solution:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111. Decision based on Non-MTUS Citation Official Disability Guidelines and United States Food and Drug Administration.

**Decision rationale:** California Medical Treatment Utilization Schedule, the Official Disability Guidelines and United States Food and Drug Administration do not recommend the use of compounded medications as these medications are noted to be largely experimental in use with few randomized controlled trials to determine efficacy or safety. Topical compounded medication is unproven as an effective treatment alternative for long term pain relief, and not supported in the guidelines. Therefore, the request is not medically necessary.