

<b>Case Number:</b>	CM14-0137703		
<b>Date Assigned:</b>	09/05/2014	<b>Date of Injury:</b>	05/01/2013
<b>Decision Date:</b>	10/08/2014	<b>UR Denial Date:</b>	08/11/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/26/2014

### 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 Pain Medicine 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 50-year-old male who reported an injury on 05/01/2013. The mechanism of injury was not provided for clinical review. The diagnoses included lumbar myofascial superimposed on lumbar disc injury, status post bilateral carpal tunnel release, and bilateral patellofemoral chondromalacia. The previous treatments included medication, surgery, and physical therapy. Within the clinical note dated 06/09/2014, it was reported the injured worker complained of low back pain. He rated his pain 4/10 in severity. Upon physical examination, the provider noted the injured worker had slightly decreased sensation in the median nerve distribution. The provider indicated the injured worker had tenderness to palpation of the mid line and paraspinal with some limitation of motion. The injured worker's right knee range of motion was 0 to 130 degrees with painful patellofemoral crepitus throughout. The left knee range of motion was 0 to 130 with painful patellofemoral crepitus throughout. The provider requested topical compound flurbiprofen 20pc and tramadol 20% gel for pain. The Request for Authorization was submitted on 08/04/2014.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Topical compound (Flurbiprofen 20%, Tramadol 20%) in base 210 grams:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical analgesics Page(s): 111-113.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical NSAIDs Page(s): 72, 111-112.

**Decision rationale:** The request for topical compound flurbiprofen 20% and tramadol 20% in base 210 grams is not medically necessary. The California MTUS Guidelines note topical NSAIDs are recommended for osteoarthritis and tendinitis, in particular, that of the knee and/or elbow and other joints that area amenable. Topical NSAIDs are recommended short term use of 4 to 12 weeks. Flurbiprofen is recommended for osteoarthritis and mild to moderate pain. Tramadol is a centrally acting synthetic opioid analgesic and is not recommended as a first line oral analgesic. There is a lack of documentation indicating the efficacy of the medication as evidenced by significant functional improvement. The request submitted failed to provide the frequency of the medication. The request submitted failed to provide a treatment site. Therefore, the request is not medically necessary.