

Case Number:	CM14-0147419		
Date Assigned:	09/15/2014	Date of Injury:	04/08/2014
Decision Date:	01/30/2015	UR Denial Date:	08/08/2014
Priority:	Standard	Application Received:	09/10/2014

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 Preventive Medicine, has a subspecialty in Occupational Medicine and is licensed to practice in Iowa. 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:

This patient is a 37 year old employee with date of injury of 4/8/14. Medical records indicate the patient is undergoing treatment for cervical disc syndrome, lumbar disc syndrome, lumbar radiculitis, insomnia, gastroesophageal reflux disease and intractable pain. Subjective complaints include low back and hip pain as well as pain to his neck, chest, upper back and bilateral shins. His low back pain occasionally radiates to his bilateral buttocks. He rates his low back pain as 7/10 and neck pain as 5/10. Objective findings include tenderness to palpation over paraspinal muscles with no noted spasm in the lumbar spine. Lumbar spine range of motion: flexion: 90 degrees; extension and lateral flexion to the left and right are all 25 degrees. The patient has a negative straight leg test. An MRI on June 14, 2014 revealed a L2-L3 3mm left forminal zone disc protrusion. Treatment has consisted of physical therapy, moist heat pad, biofreeze, Cyclobenzaprine, Tramadol, Nabumetone and Omeprazole. The utilization review determination was rendered on 8/8/2014 recommending non-certification of for Flurflex (Flurbiprofen 10%, Cyclobenzaprine 10%).

IMR ISSUES, DECISIONS AND RATIONALES

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

Flurflex (Flurbiprofen 10%, Cyclobenzaprine 10%): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Compound creams.

Decision rationale: The Expert Reviewer based his/her decision on the MTUS Chronic Pain Medical Treatment Guidelines, Topical Analgesics, page 111-113 and on the Non-MTUS Official Disability Guidelines (ODG) Pain, Compound creams. The Expert Reviewer's decision rationale: My rationale for why the requested treatment/service is or is not medically necessary: MTUS and ODG recommend usage of topical analgesics as an option, but also further details "primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed." The medical documents do not indicate failure of antidepressants or anticonvulsants. MTUS states, "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." MTUS states regarding topical muscle relaxants, "Other muscle relaxants: There is no evidence for use of any other muscle relaxant as a topical product." Topical cyclobenzaprine is not indicated for this usage, per MTUS. As such, the request for Flurflex (Flurbiprofen 10%, Cyclobenzaprine 10%) is not medically necessary.