

|                       |              |                              |            |
|-----------------------|--------------|------------------------------|------------|
| <b>Case Number:</b>   | CM14-0209608 |                              |            |
| <b>Date Assigned:</b> | 12/31/2014   | <b>Date of Injury:</b>       | 03/30/2000 |
| <b>Decision Date:</b> | 05/11/2015   | <b>UR Denial Date:</b>       | 12/01/2014 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 12/15/2014 |

### 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. 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: California

Certification(s)/Specialty: Physical Medicine & Rehabilitation

### 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 77-year-old female with a reported date of injury of 03/30/2000. The mechanism of injury was not specifically stated. The current diagnosis is neck sprain. The only clinical note submitted for this review is an MRI of the right shoulder without contrast on 08/16/2014, which revealed a chronic rotator cuff tear, tenosynovitis of the biceps tendon sheath, edematous soft tissue thickening in the rotator interval, and a degenerative tear of the posterior superior labrum. There was no Request for Authorization form submitted for this review. There were no physician progress reports submitted for this review.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Compounded Cream ( Flurbiprofen, Lidocaine 5%, Cyclobenzaprine) # 1 x 6 refills:**

Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Compounded Medications Page(s): 71.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111-113.

**Decision rationale:** The California MTUS Guidelines state any compounded product that contains at least one drug that is not recommended, is not recommended as a whole. The only FDA approved topical NSAID is diclofenac. Lidocaine is not recommended in the form of a cream, lotion or gel. Muscle relaxants are not recommended for topical use. Additionally, the request as submitted failed to indicate a frequency. Given the above, the request is not medically necessary.