

Case Number:	CM14-0216117		
Date Assigned:	01/06/2015	Date of Injury:	08/09/2008
Decision Date:	03/03/2015	UR Denial Date:	12/15/2014
Priority:	Standard	Application Received:	12/24/2014

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: Emergency Medicine

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 is a 46 year old male who injured his left hand and arm due to a fall. The date of injury was August 9, 2008. Diagnoses include cervical strain, bursitis of the left shoulder, strain of the left wrist and strain of the lumbar paraspinal muscle. On April 6, 2014, a cervical spine x-ray revealed abnormal degenerative disc disease at C4-C7. On April 7, 2014, an upper extremity x-ray was unremarkable. On July 28, 2014, the injured worker complained of left arm and low back pain. The pain was rated an 8 on a 1-10 pain scale. Physical examination revealed left wrist tenderness to palpation and swelling. Range of motion of the lumbosacral spine included trunk extension 10 degrees, lumbar spine flexion 45 degrees, right rotation 30 degrees and left rotation 30 degrees. Medications were listed as treatment. A request was made for Flurbiprofen 25% 30 GMS dispensed 7/30/2014, Lidocaine 5% 6 GM dispensed 7/30/2014 and Ultraderm base 84 GMS dispensed 7/30/2014. On December 15, 2014, utilization review denied the request.

IMR ISSUES, DECISIONS AND RATIONALES

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

Flurbiprofen 25% 30gms: Upheld

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

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

Decision rationale: The 3 topical compounds requested are often compounded together. This review will determine medical necessity based on this being using individual or as a combined compounded product. Flurbiprofen: Topical NSAIDs are shown to be superior to placebo. It should not be used long term. It may be useful. Flurbiprofen is not FDA approved for topical application. There is no justification by the provider as to why the patient requires a non-FDA approved compounded NSAID when there are multiple other approved products including over the counter medications on the market. Flurbiprofen is not medically necessary.

Lidocaine 5% 6gm: Upheld

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

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

Decision rationale: The 3 topical compounds requested are often compounded together. This review will determine medical necessity based on this being using individual or as a combined compounded product. Lidocaine: Topical lidocaine is recommended for post-herpetic neuralgia only although it may be considered as off-label use as a second line agent for peripheral neuropathic pain. It may be considered for peripheral neuropathic pain only after a trial of 1st line agent. Patient has no neuropathic related pathology and has not failed any 1st line trials. The requested treatment is not medically necessary.

Ultraderm base 84gms: Upheld

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

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

Decision rationale: This is the base for compounding creams. Since none of the requested products is medically necessary, this ultraderm base is not medically necessary.