

<b>Case Number:</b>	CM15-0114055		
<b>Date Assigned:</b>	06/22/2015	<b>Date of Injury:</b>	07/24/2012
<b>Decision Date:</b>	07/27/2015	<b>UR Denial Date:</b>	05/13/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/12/2015

### 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, Texas, Florida

Certification(s)/Specialty: Anesthesiology, Pain Management, Hospice & Palliative 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 44 year old male with a July 24, 2012 date of injury. A progress note dated April 29, 2015 documents subjective complaints (persistent pain in the lower back rated at a level of 9/10; left shoulder, left hand, and bilateral knee pain rated at a level of 9/10; left lower leg swelling and pain in the left knee with weakness; pain reduced to a level of 4/10 with medications), objective findings (decreased range of motion of the lumbar spine; tenderness to the lumbar paraspinals; positive straight leg raise on the right; decreased strength on the left at L4-L5 with 1+ swelling of the lower extremities; slight loss of range of motion of the bilateral knees; tenderness over the medial joint; decreased range of motion of the left shoulder; tenderness to the left acromioclavicular joint with slight decreased strength), and current diagnoses (lumbar spine spondylolisthesis; left shoulder superior labrum and posterior labrum tear with paralabral cyst and spinal glenoid notch; right knee anterior cruciate ligament tear; compensatory left knee strain). Treatments to date have included right knee surgery, left shoulder surgery, medications, imaging studies, and activity modifications. The treating physician documented a plan of care that included Flurbiprofen 20%, Lidocaine 5% topical cream, and Voltaren.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Topical cream: Flurbiprofen 20%, Lidocaine 5%: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111-113 of 127.

**Decision rationale:** Regarding the request for Flurbiprofen 20%, Lidocaine 5% cream, CA MTUS states that topical compound medications require guideline support for all components of the compound in order for the compound to be approved. Topical NSAIDs are indicated for "Osteoarthritis and tendonitis, in particular, that of the knee and elbow or other joints that are amenable to topical treatment: Recommended for short-term use (4-12 weeks). There is little evidence to utilize topical NSAIDs for treatment of osteoarthritis of the spine, hip or shoulder. Neuropathic pain: Not recommended as there is no evidence to support use." Topical lidocaine is "Recommended for localized peripheral pain after there has been evidence of a trial of first-line therapy (tri-cyclic or SNRI anti-depressants or an AED such as gabapentin or Lyrica)." Additionally, it is supported only as a dermal patch. Within the documentation available for review, none of the abovementioned criteria have been documented. Furthermore, there is no clear rationale for the use of topical medications rather than the FDA-approved oral forms for this patient, despite guideline recommendations. In light of the above issues, the currently requested Flurbiprofen 20%, Lidocaine 5% cream is not medically necessary.

**Voltaren:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs (non steroidal anti-inflammatory drugs).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 67-72 of 127.

**Decision rationale:** Regarding the request for Voltaren (diclofenac), Chronic Pain Medical Treatment Guidelines state that NSAIDs are recommended at the lowest dose for the shortest period in patients with moderate to severe pain. Within the documentation available for review, there is no indication that Voltaren is providing any specific analgesic benefits (in terms of percent pain reduction, or reduction in numeric rating scale), or any objective functional improvement. In the absence of such documentation, the currently requested Voltaren is not medically necessary.