

Case Number:	CM15-0116314		
Date Assigned:	06/24/2015	Date of Injury:	03/01/2014
Decision Date:	07/23/2015	UR Denial Date:	05/13/2015
Priority:	Standard	Application Received:	06/16/2015

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

Certification(s)/Specialty: Preventive Medicine, Occupational 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:

The injured worker is a 39 year old male, who sustained an industrial/work injury on 3/1/14. He reported initial complaints of pain due to injuries to multiple body parts to include back and left shoulder. The injured worker was diagnosed as having lumbar strain with spasm, lumbar facet arthritis and degenerative disc disease (DDD), and left shoulder tendinitis. Treatment to date has included medication, physical therapy, and home exercise program. Currently, the injured worker complains of left low back pain that occasionally radiates through the thigh, and more sharp electric shock or spasms in the left lower back that halts activity. Per the primary physician's progress report (PR-2) on 11/5/14, examination noted minimal lumbar tenderness in the left lower back paraspinals and facet joints, non-tender S1 joints, negative straight leg raise, left shoulder has good active range of motion (ACOM) and mildly positive impingement sign. The requested treatments include FCL (Flurbiprofen 10%, Cyclobenzaprine 4%, Lidocaine 5%) 120gm.

IMR ISSUES, DECISIONS AND RATIONALES

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

FCL (Flurbiprofen 10%, Cyclobenzaprine 4%, Lidocaine 5%) 120gm with 3 refills:

Upheld

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

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

Decision rationale: The MTUS Guidelines are very specific in stating that only FDA/Guideline approved topical agents are recommended and if an agent is not supported any compound containing that agent is not recommended. The Guidelines do not support Flurbiprofen, they specifically state that Cyclobenzaprine and this topical form of Lidocaine are not recommended. The compounded FCL (Flurbiprofen 10%, Cyclobenzaprine 4%, Lidocaine 5%) 120gm with 3 refills is not supported by Guidelines and is not medically necessary.