

<b>Case Number:</b>	CM15-0117476		
<b>Date Assigned:</b>	06/25/2015	<b>Date of Injury:</b>	12/10/2001
<b>Decision Date:</b>	07/24/2015	<b>UR Denial Date:</b>	06/09/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/18/2015

### 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: Massachusetts

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Pain Management

### 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 47 year old male, who sustained an industrial injury on December 10, 2001, incurring lower back injuries. He was diagnosed with lumbar disc disease, lumbar radiculopathy, lumbar stenosis, and facet hypertrophy. Treatment included nerve blocks, neuropathic medications, pain medications, anti-inflammatory drugs, antidepressants, and home exercise program and work modifications. He underwent a posterior lumbar fusion and decompression. Currently, the injured worker complained of constant low back pain with radiation to the right lower extremity into the foot. He complained of increased low back pain and leg pain with activity. The injured worker stated his quality of life was limited secondary to the chronic pain. The treatment plan that was requested for authorization included a prescription for Flurbiprofen topical cream.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Flurbiprofen 20% 120gm:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical analgesics, NSAIDs (non-steroidal anti-inflammatory drugs) Page(s): 111-113. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines (1) Medications for chronic pain, Topical Analgesics Page(s): 60, 111-113.

**Decision rationale:** The claimant sustained a work injury in December 2001 and continues to be treated for radiating low back pain. When seen, pain was rated at 5/10. Physical examination findings included positive straight leg raising and positive Kemp's testing. There was decreased left lower extremity sensation. There was pain with lumbar spine extension. The claimant BMI was 36. His past medical history includes GERD. Authorization for compounded topical cream was requested. Flurbiprofen is a non-steroidal anti-inflammatory medication. Compounded topical preparations of flurbiprofen are used off-label (non-FDA approved) and have not been shown to be superior to commercially available topical medications such as diclofenac. The claimant has not had a trial of topical diclofenac and this medication was not medically necessary.