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| <b>Case Number:</b>   | CM15-0123840 |                              |            |
| <b>Date Assigned:</b> | 07/08/2015   | <b>Date of Injury:</b>       | 06/01/2008 |
| <b>Decision Date:</b> | 08/10/2015   | <b>UR Denial Date:</b>       | 06/05/2015 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 06/29/2015 |

### 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: 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 62 year old male, who sustained an industrial injury on 6/01/2008. The medical records submitted for this review did not include documentation regarding the initial injury or prior treatment to date. Diagnoses include lumbar spine sprain/strain, rule out herniated nucleus pulposus, lumbar radiculitis, and right foot drop. Currently, he complained of ongoing low back pain rated 9/10 VAS. The pain radiated down bilateral lower extremities. On 6/2/15, the physical examination documented tenderness and decreased range of motion. The straight leg raise test was positive on the right side. There was atrophy noted of the right calf muscle with decreased strength and sensation. The plan of care included a prescription for a topical compound cream, (Flurbiprofen/Lidocaine (20%/5%)).

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Medication-Compound-Flurbiprofen/Lidocaine Cream-(20%/5%) - 180gm: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation California N-formulary for Workers' Comp.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines

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**Decision rationale:** Regarding the request for flurbiprofen/lidocaine 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 tendinitis, 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. Given all of the above, the requested flurbiprofen/lidocaine cream is not medically necessary.