

<b>Case Number:</b>	CM15-0126692		
<b>Date Assigned:</b>	07/13/2015	<b>Date of Injury:</b>	12/20/2014
<b>Decision Date:</b>	08/07/2015	<b>UR Denial Date:</b>	06/18/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/30/2015

### 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: New Jersey, Alabama, California  
 Certification(s)/Specialty: Neurology, Neuromuscular 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 26-year-old female, who sustained an industrial injury on December 20, 2014. She reported injury to the left shoulder, left leg, bilateral knees, mid lower back, neck and left elbow. The injured worker was diagnosed as having cervical spine sprain/strain cervicogenic headaches, thoracic spine sprain/strain and lumbar spine sprain/strain. Treatment to date has included medication. On June 3, 2015, the injured worker complained of low back pain radiating to the left hip rated as a 5 on a 1-10 pain scale. She also complained of neck pain rated as a 3 on the pain scale and left elbow pain rated as a 1 on the pain scale. The treatment plan included medication, chiropractic treatment, diagnostic studies and a solar care FIR heating system. On June 18, 2015, Utilization Review non-certified the request for one prescription of Naproxen 350 mg #60 with one refill and one solar care FIR heating system, citing California MTUS and Official Disability Guidelines.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**(1) Prescription of Flurbioprofen cream with 1 refill: Upheld**

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

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

**Decision rationale:** According to MTUS, in Chronic Pain Medical Treatment, guidelines section Topical Analgesics (page 111), topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. Many agents are combined to other pain medications for pain control. That is limited research to support the use of many of these agents. Furthermore, according to MTUS guidelines, any compounded product that contains at least one drug or drug class that is not recommended is not recommended. Flurbiprofen, a topical analgesic is not recommended by MTUS guidelines. Based on the above, Flurbiprofen cream with 1 refill is not medically necessary.

**1 solar care FIR heating system:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Infrared therapy (IR).

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Cold/heat packs. ([http://www.worklossdatainstitute.verioiponly.com/odgtwc/low\\_back.htm#SPECT](http://www.worklossdatainstitute.verioiponly.com/odgtwc/low_back.htm#SPECT)).

**Decision rationale:** According to ODG guidelines, cold therapy is "recommended as an option for acute pain. At-home local applications of cold packs in first few days of acute complaint; thereafter, applications of heat packs or cold packs. (Bigos, 1999) (Airaksinen, 2003) (Bleakley, 2004) (Hubbard, 2004) Continuous low-level heat wrap therapy is superior to both acetaminophen and ibuprofen for treating low back pain. (Nadler 2003) The evidence for the application of cold treatment to low-back pain is more limited than heat therapy, with only three poor quality studies located that support its use, but studies confirm that it may be a low risk low cost option. (French-Cochrane, 2006) There is minimal evidence supporting the use of cold therapy, but heat therapy has been found to be helpful for pain reduction and return to normal function. (Kinkade, 2007) See also Heat therapy; Biofreeze cryotherapy gel." There is no evidence to support the efficacy of hot and cold therapy in this patient. There is not enough documentation relevant to the patient work injury to determine the medical necessity for cold therapy. Cold and hot therapy could be used as an option for acute pain. However, there are no controlled studies supporting the use of cold and hot therapy in chronic pain. Therefore, the request for Solar-Care FIR Heating System is not medically necessary.