

Case Number:	CM15-0127127		
Date Assigned:	07/15/2015	Date of Injury:	11/21/2009
Decision Date:	09/24/2015	UR Denial Date:	06/09/2015
Priority:	Standard	Application Received:	07/01/2015

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

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 59 year old female who sustained an industrial injury on 11/21/09. The injured worker was diagnosed as having lumbar thoracic radiculitis. Currently, the injured worker was with complaints of pain in the low back, right shoulder and left knee as well as headaches. Previous treatments included oral pain medication, H wave therapy, rest, topical analgesics. The injured worker was authorized a gym membership but provider documentation dated 6/11/15 notes the injured worker has not initiated the membership at a gym. Previous diagnostic studies were not noted. The injured work status was noted as permanently disabled. The injured workers pain level was noted as 5/10 with the use of medications and 8/10 without the use of medications. Physical examination was notable for tenderness to the lumbar spine, facet joint with decreased flexion, extension and decreased lateral bending. The plan of care was for Flurbiprofen compound cream 120 grams.

IMR ISSUES, DECISIONS AND RATIONALES

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

Flurbiprofen compound cream #120gm: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines
Topical Analgesics Page(s): 111-112.

Decision rationale: The patient presents on 06/11/15 with intermittent headaches, lower back pain, right shoulder pain, and left knee pain. The pain is rated 8/10 without medications, 5/10 with medications. The patient's date of injury is 11/21/09. Patient has no documented surgical history directed at these complaints. The request is for FLURBIPROFEN COMPOUND CREAM #120 GM. The RFA was not provided. Physical examination dated 06/11/15 reveals tenderness to palpation of the lumbar spine, lumbar facet joints, with decreased range of lumbar motion noted in all planes. The patient is currently prescribed Voltaren gel, Percocet, and Zanaflex. Patient is permanently disabled. MTUS Guidelines, Topical Analgesics section, under Non-steroidal anti-inflammatory agents, page 111-112 has the following: "The efficacy in clinical trials for this treatment modality has been inconsistent and most studies are small and of short duration. Topical NSAIDs have been shown in meta-analysis to be superior to placebo during the first 2 weeks of treatment for osteoarthritis, but either not afterward, or with a diminishing effect over another 2-week period...this class in general is only recommended for relief of osteoarthritis pain in joints that lend themselves to topical treatment (ankle, elbow, foot, hand, knee, and wrist)." In regard to the compounded topical cream containing Flurbiprofen, the requesting physician has failed to specify where it is to be applied. Topical NSAIDs are only supported for peripheral complaints, this patient presents with lower back pain, right shoulder pain, and right knee pain. While there is evidence of a peripheral complaint for which topical NSAIDs are considered a conservative option, the provider does not clearly define where this cream is to be applied. MTUS guidelines indicate that such creams are not supported for complaints in the spine or shoulder. Without documentation that the requested cream is being used for a peripheral complaint, the request cannot be substantiated. This request IS NOT medically necessary.