

<b>Case Number:</b>	CM15-0040617		
<b>Date Assigned:</b>	03/10/2015	<b>Date of Injury:</b>	11/30/2013
<b>Decision Date:</b>	05/11/2015	<b>UR Denial Date:</b>	02/09/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/03/2015

### 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 22-year-old male who reported an injury on 11/30/2013. The mechanism of injury was no specifically stated; however, it is noted that the injured worker sustained a crush injury to the pelvis. The current diagnoses include crush injury to the right hand, crush injury to the pelvis, lumbar spine fractures, chronic lumbar spine pain, right carpal tunnel syndrome, status post right carpal tunnel release, right hand numbness, gastrointestinal symptoms, an antalgic gait, facet degeneration of the lumbar spine, and mild foraminal narrowing with disc bulging at L4-5. The injured worker presented on 02/16/2015 for a follow up evaluation with complaints of persistent pain over multiple areas of the body. The injured worker was utilizing Tylenol No. 3 on an as needed basis. Upon examination of the cervical spine, there was decreased range of motion in all planes with tenderness at the suboccipital region, decreased sensation in the right upper extremity, 4/5 motor weakness in the right upper extremity, and 2+ deep tendon reflexes bilaterally. Examination of the lumbar spine also revealed decreased range of motion with tenderness to palpation, hypertonicity, positive Kemp's testing bilaterally, diminished deep tendon reflexes bilaterally, and tenderness over the spinous process as well as at L4-S1. There was decreased range of motion and weak grip strength of the right wrist. There was positive Patrick's sign, tenderness over the iliac crest, decreased range of motion of the right hip, left sacroiliac joint tenderness, and residual pain in the left sacroiliac joint, status post fractures of the right hip. Recommendations at that time included a spine surgeon consultation, physical therapy for the cervical spine, and continuation of Tylenol No. 3. There was no Request for Authorization form submitted for this review.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Tylenol #3, 30-300mg, #90:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 77-80.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 35.

**Decision rationale:** The California MTUS Guidelines recommend codeine as an option for mild to moderate pain. It is used as a single agent or in combination with acetaminophen and other products for treatment of mild to moderate pain. In this case, it is noted that the injured worker has continuously utilized the above medication. There is no documentation of objective functional improvement. The injured worker continues to present with 8/10 pain over multiple areas of the body. There is also no frequency listed in the request. As such, the request is not medically appropriate.

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

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

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

**Decision rationale:** The California MTUS Guidelines state any compounded product that contains at least 1 drug that is not recommended, is not recommended as a whole. The only FDA-approved topical NSAID is diclofenac. Lidocaine is not recommended in the form of a cream, lotion, or gel. There is also no frequency listed in the request. Given the above, the request is not medically appropriate.