

| | | | |
|-----------------------|--------------|------------------------------|------------|
| Case Number: | CM15-0064367 | | |
| Date Assigned: | 04/10/2015 | Date of Injury: | 09/26/2014 |
| Decision Date: | 05/13/2015 | UR Denial Date: | 03/09/2015 |
| Priority: | Standard | Application Received: | 04/04/2015 |

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: Family Practice

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 42 year old male who sustained an industrial injury on 09/26/2014. Diagnoses include lumbar sprain/strain, thoracic sprain/strain, muscle spasm of the back, lumbar intervertebral disc disorder with myelopathy, and sciatica. Treatment to date has included diagnostic studies, medications, back support, heat therapy, cold packs, physical therapy, and chiropractic sessions. A physician progress note dated 03/05/2015 documents the injured worker complains of lumbar pain and rates is as an 8 out of 10 on the pain scale, the best his pain is 4 out of 10. He has numbness and tingling in the right anterior leg, left anterior leg, left posterior leg and right posterior leg. He has tenderness at the lumbar area, right anterior leg, left lumbar, right lumbar, left sacroiliac, right sacroiliac and right pelvic. Lumbar ranges of motion are restricted. The treatment plan is for topical medication, and a home interferential stimulator. Treatment requested is for compound: FCL (Flurbiprofen 20%, Tramadol 20%) 180 grams.

IMR ISSUES, DECISIONS AND RATIONALES

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

Compound: FCL (Flurbiprofen 20%, Tramadol 20%) 180 grams: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical analgesics for chronic pain Page(s): 111-113.

Decision rationale: This patient receives treatment for chronic low back and muscle spasms of the lumbar region. This dates back to a work-related injury dated 09/26/2014. This review addresses a treatment request for a compounded topical analgesic. Topical analgesics are considered experimental in use, because clinical trials have failed to show efficacy. In addition, if a compounded product contains at least one drug or drug class that is not recommended, then that compounded product cannot be recommended. Flurbiprofen is an NSAID medication. There are no recommended NSAIDs approved for use in a topical formulation. Tramadol is a mu-opioid receptor agonist, an opioid. No opioid medications are recommended in their topical formulation to treat chronic pain. This compounded topical medicinal is not medically necessary.