

**MAXIMUS FEDERAL SERVICES, INC.**

Independent Medical Review

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**Notice of Independent Medical Review Determination**

Dated: 11/21/2013

[REDACTED]

[REDACTED]

Employee:	[REDACTED]
Claim Number:	[REDACTED]
Date of UR Decision:	7/23/2013
Date of Injury:	4/10/2007
IMR Application Received:	8/5/2013
MAXIMUS Case Number:	CM13-0007361

- 1) MAXIMUS Federal Services, Inc. has determined the request for **FluriFlex cream is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for **TGHot cream is not medically necessary and appropriate.**

## INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 8/5/2013 disputing the Utilization Review Denial dated 7/23/2013. A Notice of Assignment and Request for Information was provided to the above parties on 9/11/2013. A decision has been made for each of the treatment and/or services that were in dispute:

- 1) MAXIMUS Federal Services, Inc. has determined the request for **FluriFlex cream is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for **TGHot cream is not medically necessary and appropriate.**

### **Medical Qualifications of the Expert Reviewer:**

The independent Medical Doctor who made the decision has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Physical Medicine and Rehabilitation, and is licensed to practice in Oklahoma. 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 treatments and/or services at issue.

### **Expert Reviewer Case Summary:**

The patient is a 46-year-old female who reported an injury on 04/10/2007 while she was walking in a parking lot, she twisted her ankle causing her to fall landing on her right knee. The patient later complained of shoulder pain and underwent extensive conservative therapy to include physical therapy and manipulation, acupuncture, injections, and prescribed medications. MRI revealed there was no evidence of a tear. Nerve conduction study was conducted for the right upper extremity which revealed mild right carpal tunnel syndrome. The patient received right shoulder arthroscopic and Mumford procedure that provided 80% overall improvement. The patient's diagnoses included cervical discopathy, bilateral shoulder overuse tendinitis, right shoulder impingement shoulder, teres minor syndrome in the right upper extremity, and status post right shoulder rotator cuff repair arthroscopic surgery on 01/10/2011. The patient's treatment plan included FluriFlex cream and TGHot cream.

### **Documents Reviewed for Determination:**

The following relevant documents received from the interested parties and the documents provided with the application were reviewed and considered. These documents included:

- Application of Independent Medical Review
- Utilization Review Determination
- Medical Records from Claims Administrator
- Medical Treatment Utilization Schedule (MTUS)

**1) Regarding the request for FluriFlex cream:**

Section of the Medical Treatment Utilization Schedule Relied Upon by the Expert Reviewer to Make His/Her Decision

The Claims Administrator based its decision on MTUS, Compounded Medications, which is a part of the MTUS and the Official Disability Guidelines (ODG) Pain Chapter, which is not a part of the MTUS.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Topical Analgesics, page111-112, which is a part of MTUS.

Rationale for the Decision:

The MTUS Guidelines state, "Topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety." The clinical documentation submitted for review does not provide evidence that the employee has failed to respond to oral medications and the efficacy of this medication is not supported by a pain assessment or documentation of increased functional capabilities. Additionally, the clinical documentation submitted for review does not provide evidence of the necessity for 2 topical analgesics. The request includes a concurrent request for an additional topical analgesic, which would not be supported. **The request for FluriFlex cream is not medically necessary and appropriate.**

**2) Regarding the request for TGHOT cream:**

Section of the Medical Treatment Utilization Schedule Relied Upon by the Expert Reviewer to Make His/Her Decision

The Claims Administrator based its decision on MTUS, Compounded Medications, which is a part of the MTUS and the Official Disability Guidelines (ODG) Pain Chapter, which is not a part of the MTUS.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Topical Analgesics, page111-112, which is a part of MTUS.

Rationale for the Decision:

The MTUS Guidelines state, "Topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety." The clinical documentation submitted for review does not provide evidence that the employee has failed to respond to oral medications and the efficacy of this medication is not supported by a pain assessment or documentation of increased functional capabilities. Additionally, the clinical documentation submitted for review does not provide evidence of the necessity for 2 topical analgesics. **The request for TGHOT cream is not medically necessary and appropriate.**

**Effect of the Decision:**

The determination of MAXIMUS Federal Services and its physician reviewer is deemed to be the final determination of the Administrative Director, Division of Workers' Compensation. With respect to the medical necessity of the treatment in dispute, this determination is binding on all parties.

In accordance with California Labor Code Section 4610.6(h), a determination of the administrative director may be reviewed only if a verified appeal is filed with the appeals board for hearing and served on all interested parties within 30 days of the date of mailing of the determination to the employee or the employer. The determination of the administrative director shall be presumed to be correct and shall be set aside only upon proof by clear and convincing evidence of one or more of the grounds for appeal listed in Labor Code Section 4610.6(h)(1) through (5).

Sincerely,

Paul Manchester, MD, MPH  
Medical Director

cc: Department of Industrial Relations  
Division of Workers' Compensation  
1515 Clay Street, 18<sup>th</sup> Floor  
Oakland, CA 94612

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Disclaimer: MAXIMUS is providing an independent review service under contract with the California Department of Industrial Relations. MAXIMUS is not engaged in the practice of law or medicine. Decisions about the use or nonuse of health care services and treatments are the sole responsibility of the patient and the patient's physician. MAXIMUS is not liable for any consequences arising from these decisions.