

<b>Case Number:</b>	CM13-0020637		
<b>Date Assigned:</b>	10/11/2013	<b>Date of Injury:</b>	01/21/2003
<b>Decision Date:</b>	05/05/2014	<b>UR Denial Date:</b>	08/21/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/05/2013

### 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. The expert reviewer is Board Certified in Physical Medicine & Rehabilitation and is licensed to practice in Illinois. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### 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 patient is a 56-year-old male who reported an injury on 01/21/2003 after a twisting motion of his right ankle, which caused a backward fall. The patient reportedly injured his back, neck, bilateral legs, and right ankle. The patient's treatment history has included multiple ankle surgeries, physical therapy, chiropractic care, and acupuncture. The patient underwent an MRI of the right ankle in 06/2013 that documented the patient's evidence of plantar fasciitis. The patient was evaluated on 07/11/2013 that documented the patient had constant low back pain rated at a 7/10 to 8/10, and right ankle pain rated at a 9/10. The patient had full range of motion of the lumbar spine but pain in all planes and increased range of motion of the right ankle. The patient's diagnoses included lumbago, lumbar radiculitis, lumbar spine multilevel disc bulging, facet joint hypertrophy, and right plantar fasciitis.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**CAPSAICIN 0.025%, FLURBIPROFEN 20%, TRAMADOL 10%, MENTHOL 2%, CAMPHOR 2% COMPOUND MEDICATION 240GM:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines, Topical Medications..

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

**Decision rationale:** The requested capsaicin 0.025%, flurbiprofen 20%, tramadol 10%, menthold 2%, camphor 2% compound medication 240 gm is not medically necessary or appropriate. The California Medical Treatment Utilization Schedule does recommend the use of capsaicin and flurbiprofen as topical analgesics for patients who have failed to respond to other first-line treatments. The clinical documentation submitted for review does indicate that the patient has liver dysfunction that makes oral medications contraindicative to this patient. Therefore, the need for topical analgesics such as capsaicin and flurbiprofen would be supported. However, the compounded medication also contains tramadol. Peer-reviewed literature does not support the need for topical opioids, as it is largely experimental and is not supported by scientific evidence for safety and efficacy. The California Medical Treatment Utilization Schedule recommends that any medication that contains at least 1 drug (or drug class) that is not supported, is not recommended. As such, the requested capsaicin 0.025%, flurbiprofen 20%, tramadol 10%, menthold 2%, camphor 2% compound medication 240 gm is not medically necessary or appropriate.

**FLURBIPROFEN 20%, TRAMADOL 20% COMPOUND MEDICATION 240GM:**  
Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines, Topical Medications..

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

**Decision rationale:** The Expert Reviewer's decision rationale: The requested flurbiprofen 20%, tramadol 20% compound medication 240 gm is not medically necessary or appropriate. The California Medical Treatment Utilization Schedule does support the use of flurbiprofen as a topical analgesic when orals formulations of nonsteroidal anti-inflammatory drugs are contraindicated to the patient. The clinical documentation submitted for review does indicate that the patient has severe liver dysfunction, making oral medications contraindicative to this patient. Therefore, the use of flurbiprofen would be supported. However, peer-reviewed literature does not support the use of topical opioids such as tramadol, as it is considered experimental and not supported by scientific studies. The California Medical Treatment Utilization Schedule states that any compounded medication which contains at least 1 drug (or drug class) that is not supported by guideline recommendations is not recommended. As such, the requested 20%, tramadol 20% compound medication 240 gm is not medically necessary or appropriate.

**FLURBIPROFEN 20%, TRAMADOL 20% COMPOUND MEDICATION 10GM:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines, Topical Medications..

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

**Decision rationale:** The requested flurbiprofen 20%, tramadol 20% compound medication 10 gm is not medically necessary or appropriate. The California Medical Treatment Utilization Schedule does support the use of flurbiprofen as a topical analgesic when oral formulations of nonsteroidal anti-inflammatory drugs are contraindicated to the patient. The clinical documentation submitted for review does indicate that the patient has severe liver dysfunction, making oral medications contraindicative to this patient. Therefore, the use of flurbiprofen would be supported. However, peer-reviewed literature does not support the use of topical opioids such as tramadol, as it is considered experimental and not supported by scientific studies. The California Medical Treatment Utilization Schedule states that any compounded medication which contains at least 1 drug (or drug class) that is not supported by guideline recommendations is not recommended. As such, the requested flurbiprofen 20%, tramadol 20% compound medication 10 gm is not medically necessary or appropriate.

**MEDROX PATCHES, #30:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines, Medication for chronic pain and topical analgesics. P.

**Decision rationale:** The requested Medrox Patches #30 are not medically necessary or appropriate. The requested medication is a topical patch that contains methylsalicylate, menthol, and capsaicin. The California Medical Treatment Utilization Schedule does support the use of capsaicin as a topical analgesic for patients who cannot tolerate oral medications, or when oral medications are contraindicated. The clinical documentation submitted for review does indicate that the patient has severe liver dysfunction and cannot tolerate oral formulations of medications and that they are contraindicated for this patient. However, the California Medical Treatment Utilization Schedule recommends that medications used in the management of chronic pain be supported by documentation of functional benefit and pain relief. The clinical documentation submitted for review does provide evidence that the patient has been on this medication since at least 03/2013. The clinical documentation fails to provide any evidence that the patient has any pain relief or functional benefit as a result of this medication. As such, the requested Medrox Patches #30 are not medically necessary or appropriate.

**SHOCKWAVE TREATMENTS TO THE RIGHT FOOT, #3:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 14 Ankle and Foot Complaints Page(s): 371.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 14 Ankle and Foot Complaints Page(s): 366-367.

**Decision rationale:** The requested shockwave treatments to the right foot #3 are not medically necessary or appropriate. The American College of Occupational and Environmental Medicine

does support the use of shockwave treatments for plantar fasciitis as an option for treatment. Official Disability Guidelines further recommend that patients have failed to respond to at least 3 forms of conservative therapy. The clinical documentation submitted for review does provide evidence that the patient has participated in physical therapy, and does not have adequate pain control provided by medications. However, no documentation that the patient has had any corticosteroid injections, orthotics, or rest and ice. Additionally, the clinical documentation submitted for review fails to provide any physical evidence to support the imaging study of plantar fasciitis. The patient's most recent clinical documentation fails to provide an adequate assessment of the patient's heel pain to support plantar fasciitis. As such, the requested shockwave treatments to the right foot #3 is not medically necessary or appropriate.