

Case Number:	CM13-0054187		
Date Assigned:	03/31/2014	Date of Injury:	04/20/1999
Decision Date:	09/10/2014	UR Denial Date:	11/11/2013
Priority:	Standard	Application Received:	11/19/2013

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 Occupational Medicine and is licensed to practice in California. 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 has filed a claim for post-right shoulder arthroscopy with subacromial decompression associated with an industrial injury date of April 20, 1999. Review of progress notes indicates improvement of right shoulder range of motion, with slight pain upon abduction. Patient reports continued pain symptoms in the left ankle and left knee, which have improved with cortisone injection and physical therapy. Patient also reports right knee pain. Examination of the right shoulder showed limited range of motion with mild tenderness over the AC joint. Examination of the left ankle showed tenderness over the plantar aspect and calcaneus. Regarding the left knee, there was medial joint line with crepitus and slight decrease in flexion. Examination of the right knee showed crepitus and decreased range of motion, tenderness over the joint lines, and positive patellar grind test. Treatment to date has included topical analgesics, physical therapy, home exercises, glucosamine, opioids, injection to the left ankle, left knee arthroscopy in August 2006, right knee arthroscopy in October 2007, and right shoulder arthroscopic surgeries in December 2004 and May 2013. Utilization review from November 11, 2013 denied the requests for continued physical therapy as there was no documentation of significant deficits, and the patient is participating in a self-directed home exercise program; Norco 10/325mg #60 as there was no documentation regarding pain relief and improved function with this medication; and Fluriflex 15/10% and TGHOT 8/10/2/2/0.05% as these compounds are not recommended for topical use.

IMR ISSUES, DECISIONS AND RATIONALES

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

CONTINUE PHYSICAL THERAPY FOR THE LEFT KNEE, 2 TIMES A WEEK FOR 4 WEEKS: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99..

Decision rationale: Page 98-99 of the CA MTUS Chronic Pain Medical Treatment Guidelines stress the importance of a time-limited treatment plan with clearly defined functional goals, frequent assessment and modification of the treatment plan based upon the patient's progress in meeting those goals, and monitoring from the treating physician regarding progress and continued benefit of treatment. In this case, there was documentation that the patient had previous physical therapy to the left knee. However, there is no documentation describing these sessions, and the objective functional benefits derived. Also, the patient is already involved in a self-directed home exercise program, and it is unclear as to why additional physical therapy sessions are needed at this time. Therefore, the request for continue physical therapy for the left knee, 2x4 was not medically necessary.

CONTINUE PHYSICAL THERAPY FOR THE LEFT ANKLE, 2 TIMES A WEEK FOR 4 WEEKS: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99..

Decision rationale: Page 98-99 of the CA MTUS Chronic Pain Medical Treatment Guidelines stress the importance of a time-limited treatment plan with clearly defined functional goals, frequent assessment and modification of the treatment plan based upon the patient's progress in meeting those goals, and monitoring from the treating physician regarding progress and continued benefit of treatment. In this case, there was documentation that the patient had previous physical therapy to the left ankle. However, there is no documentation describing these sessions, and the objective functional benefits derived. Also, the patient is already involved in a self-directed home exercise program, and it is unclear as to why additional physical therapy sessions are needed at this time. Therefore, the request for continue physical therapy for the left ankle, 2x4 was not medically necessary.

PRESCRIPTION OF NORCO 10/325MG #60, ONE PO Q6-8 PRN: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use; On-Going Management Page(s): 78-82.

Decision rationale: As noted on pages 78-82 of the CA MTUS Chronic Pain Medical Treatment Guidelines, there is no support for ongoing opioid treatment unless there is ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. Patient has been on this medication since June 2013. Although the patient is status post right shoulder surgery, there is no documentation regarding symptomatic improvement or objective functional benefits derived from this medication. Therefore, the request for Norco 10/325mg #60 was not medically necessary.

PRESCRIPTION OF FLURIFLEX 15/10% 180GM CREAM, APPLY A THIN LAYER TO AFFECTED AREA TWICE DAILY: Upheld

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

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

Decision rationale: Fluriflex contains flurbiprofen 10% and cyclobenzaprine 10%. According to CA MTUS Chronic Pain Medical Treatment Guidelines pages 111-113, any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Cyclobenzaprine is not recommended for use as a topical analgesic. In addition, there is little to no research as for the use of flurbiprofen in compounded products. There is no documentation regarding failure of or intolerance of conventional oral pain medications in this patient. The components of Fluriflex are also not recommended for topical application. Therefore, the request for Fluriflex 15/10% 180g cream was not medically necessary.

TG HOT 8/10/2/2/.05% 180GM CREAM, APPLY A THIN LAYER TO AFFECTED AREA TWICE DAILY: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Capsaicin, topical Page(s): 111-113. page 28;. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain chapter, Topical salicylates.

Decision rationale: TG Hot contains tramadol 8%/ gabapentin 10%/ menthol 2%/ camphor 2%/ capsaicin 0.05%. As noted on page 111-113 of the Chronic Pain Medical Treatment Guidelines, many agents are compounded as monotherapy or in combination for pain control Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Gabapentin is not recommended for use as a topical analgesic. Regarding the Capsaicin component, CA MTUS Chronic Pain Medical Treatment Guidelines on page 28 states that topical Capsaicin is only recommended as an option when there was failure to respond or

intolerance to other treatments; with the 0.025% formulation indicated for osteoarthritis. There is no discussion regarding increased efficacy with a 0.05% formulation of capsaicin. Regarding the Menthol component, CA MTUS does not cite specific provisions, but the ODG Pain Chapter states that the FDA has issued an alert in 2012 indicating that topical OTC pain relievers that contain menthol, methyl salicylate, or capsaicin, may in rare instances cause serious burns. There is no documentation regarding failure of or intolerance of conventional oral pain medications in this patient. There is no discussion regarding the need for variance from the guidelines. Therefore, the request for TGHot 8/10/2/2/0.05% 180g cream was not medically necessary.