

Case Number:	CM13-0069007		
Date Assigned:	01/03/2014	Date of Injury:	07/07/2010
Decision Date:	05/22/2014	UR Denial Date:	11/27/2013
Priority:	Standard	Application Received:	12/20/2013

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 and Rehabilitation 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 injured worker is a 65-year-old male who reported an injury on 07/07/2010 due to cumulative trauma while performing normal job duties. The injured worker developed chronic pain to the bilateral upper extremities that was managed with physical therapy and multiple medications. The injured worker was evaluated on 10/28/2013. It was noted that the injured worker had participated in 14 visits of postsurgical physical therapy for right carpal tunnel release in 05/2013. It was noted that the injured worker continued to experience 4/10 to 5/10 of the right hand and upper back. Physical findings included hypersensitivity over the surgical site with tenderness to palpation to the carpal tunnel of the right wrist. Left wrist examination revealed mildly reduced range of motion with a positive Tinel's and Phalen's sign. It was documented that the injured worker was administered topical medications. The injured worker's diagnoses included left upper extremity overuse tendinopathy, right index finger degenerative joint disease, left carpal tunnel syndrome, trigger finger of the bilateral hands, and status post right wrist surgery. The request was made for additional physical therapy, Fluriflex cream, and TGIce cream.

IMR ISSUES, DECISIONS AND RATIONALES

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

FLURIFLEX CREAM 180GM: Upheld

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

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

Decision rationale: The requested Fluriflex cream 180gm is not medically necessary or appropriate. The requested medication is a topical analgesic that contains Flurbiprofen and Cyclobenzaprine. California Medical Treatment Utilization Schedule does not support the use of nonsteroidal anti-inflammatory drugs as topical analgesics unless there is documentation that the injured worker is unable to tolerate oral formulations of this medication, or when oral formulations are contraindicative to the injured worker. The clinical documentation submitted for review does not indicate that the injured worker cannot tolerate oral formulations of nonsteroidal anti-inflammatory drugs. Additionally, the requested medication contains Cyclobenzaprine. California Medical Treatment Utilization Schedule does not recommend the use of muscle relaxants as topical analgesics as there is little scientific evidence to support the efficacy and safety of these medications. California Medical Treatment Utilization Schedule states that any medication that contains at least 1 drug or drug class that is not supported is not recommended. As such, the requested Fluriflex cream 180gm is not medically necessary or appropriate. Additionally, the request does not include a quantity or frequency of treatment. Therefore, the appropriateness of the request itself cannot be determined.

TGICE CREAM 180GM: Upheld

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

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

Decision rationale: The requested TGIce cream 180gm is not medically necessary or appropriate. This is a compounded medication that contains Camphor, Menthol, Tramadol, and Gabapentin. California Medical Treatment Utilization Schedule does support the use of Menthol in the management of chronic pain related to osteoarthritis. The clinical documentation submitted for review does not specifically identify that the injured worker's pain is generated by osteoarthritis. Additionally, California Medical Treatment Utilization Schedule does not recommend the use of Gabapentin as a topical analgesic as there is little scientific evidence to support the efficacy and safety of this medication in this formulation. California Medical Treatment Utilization Schedule and Official Disability Guidelines do not address topical opioids. However, peer reviewed literature does not support the use of opioids in a topical formulation as there is little scientific evidence to support the efficacy and safety of these medications. California Medical Treatment Utilization Schedule states that any medication that contains at least 1 drug or drug class that is not supported by guideline recommendations is not recommended. As such, the requested TGIce cream 180gm is not medically necessary or appropriate. Additionally, the request as it is submitted does not provide a frequency or quantity. Therefore, the appropriateness of the request itself cannot be determined. As such, the requested TGIce cream 180gm is not medically necessary or appropriate.

