

Case Number:	CM14-0001279		
Date Assigned:	01/22/2014	Date of Injury:	02/19/2000
Decision Date:	06/27/2014	UR Denial Date:	12/11/2013
Priority:	Standard	Application Received:	12/13/2013

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 Orthopedic Surgery and is licensed to practice in Texas. 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 52 year old male injured on 02/19/00 due to an undisclosed mechanism of injury. Current diagnoses include cervical thoracic strain, right shoulder impingement syndrome, lumbar strain, lumbar facet disorder/discopathy, lumbar radiculopathy, thoracic fracture, and head trauma. The clinical note dated 10/28/13 indicates the injured worker presented with complaints of head pain rated at 8/10, aching right shoulder pain extending into the upper back rated at 8/10, aching right elbow pain rated at 8/10, aching low back pain rated at 10/10, and pins and needles sensation in the left calf area. Physical examination of the lumbar spine revealed limited range of motion, significant muscle spasm to the left greater than right thoracolumbar paraspinal muscles, sciatic stretch and straight leg raise was negative, and trunk rotation aggravated the chief complaint. The documentation indicates the injured worker was not taking oral medications at the time of the assessment. Prior conservative treatment included physical and manipulating therapy, acupuncture, injections, medication management, and shockwave therapy. The initial request for Fluriflex cream 180 grams and TG Ice Cream 180 grams between 10/28/13 and 02/02/14 was conditionally non-certified on 12/11/13 due to a lack of additional information.

IMR ISSUES, DECISIONS AND RATIONALES

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

THE REQUEST FOR 1 PRESCRIPTION FOR FLURIFLEX CREAM 180GM .: 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 9792.20, TOPICAL ANALGESICS Page(s): 111.

Decision rationale: As noted on page 111 of the Chronic Pain Medical Treatment Guidelines, the safety and efficacy of compounded medications has not been established through rigorous clinical trials. Topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. There is no indication in the documentation that these types of medications have been trialed and/or failed. Further, CA MTUS, Food and Drug Administration, and Official Disability Guidelines require that all components of a compounded topical medication be approved for transdermal use. Therefore the request for 1 prescription for Fluriflex cream 180gm is not recommended as medically necessary as it does not meet established and accepted medical guidelines

THE REQUEST OF 1 PRESCRIPTION FOR TGICE CREAM 180GM: 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 9792.20, TOPICAL ANALGESICS Page(s): 111.

Decision rationale: As noted on page 111 of the Chronic Pain Medical Treatment Guidelines, the safety and efficacy of compounded medications has not been established through rigorous clinical trials. Topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. There is no indication in the documentation that these types of medications have been trialed and/or failed. Further, CAMTUS, Food and Drug Administration, and Official Disability Guidelines require that all components of a compounded topical medication be approved for transdermal use. Therefore the request of 1 prescription for TGIce cream 180gm is not medically necessary as it does not meet established and accepted medical guidelines.