

Case Number:	CM14-0009876		
Date Assigned:	02/21/2014	Date of Injury:	12/18/2008
Decision Date:	06/25/2014	UR Denial Date:	01/17/2014
Priority:	Standard	Application Received:	01/27/2014

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 59 year old female injured on 12/18/08 due to an undisclosed mechanism of injury. Current diagnoses included right shoulder impingement syndrome/tendinopathy, status post right shoulder arthroscopy, lumbar discopathy, left shoulder impingement syndrome, status post left shoulder arthroscopy. Clinical note dated 12/16/13 indicated the injured worker presented with ongoing low back pain. The injured worker reported shoulder was feeling better status post shoulder surgery and continued home therapy. The injured worker was pending evaluation and treatment for lumbar spine epidural consultation and further physical therapy for low back pain. On physical examination tenderness to the left shoulder with full overhead reach with weakness against resistance, and grip strength was decreased with overall improvement since surgery. Physical examination of lumbar spine revealed tenderness, spasm, and tightness in the paralumbar musculature with reduced range of motion and slow gait. The injured worker was provided prescriptions for topical analgesics, Norco 10/325mg every six to eight hours, indomethacin 25mg three times daily, and Kronos lumbar support. Multiple urine drug screens had been obtained throughout injured worker care; however, no results were discussed or provided in the clinical documentation. The initial request for Kronos lumbar support, Norco 10/325mg #120 one by mouth every six to eight hours, fluriflex 15/10% 180g cream to apply to affected area twice daily as directed by physician, TG ice 8/10/2/2% 180g cream to apply a thin layer to affected area twice daily as directed by physician, and retrospective review for urine screen as was initially non-certified on 01/17/14.

IMR ISSUES, DECISIONS AND RATIONALES

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

KRONOS LUMBAR SUPPORT: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: ACOEM, CHAPTER 12 LOW BACK COMPLAINTS, 301

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Low Back Disorders, Lumbar Supports.

Decision rationale: As noted in the Low back disorders section of the CAMTUS, lumbar support (corset) is not recommended for the treatment of low back disorders. They are not recommended for prevention of back pain; however, recommended as an option for compression fractures and specific treatment of spondylolisthesis, documented instability, and for treatment of nonspecific low back pain. As such, the request for Kronos lumbar support is not recommended as medically necessary.

NORCO 10/325 MG #120 ONE (1) BY MOUTH EVERY SIX (6) TO EIGHT (8): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: CHRONIC PAIN MEDICAL TREATMENT GUIDELINES, OPIOIDS,

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use Page(s): 77.

Decision rationale: As noted on page 77 of the Chronic Pain Medical Treatment Guidelines, patients must demonstrate functional improvement in addition to appropriate documentation of ongoing pain relief to warrant the continued use of narcotic medications. There is no clear documentation regarding the functional benefits or any substantial functional improvement obtained with the continued use of narcotic medications. As the clinical documentation provided for review does not support an appropriate evaluation for the continued use of narcotics as well as establish the efficacy of narcotics, the medical necessity of Norco 10/325 mg #120 one (1) by mouth every six (6) to eight (8) cannot be established at this time.

FLURIFLEX 15/10% 180GM CREAM TO APPLY A THIN TO AFFECTED AREA TWICE DAILY AS DIRECTED BY PHYSICIAN: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: CHRONIC PAIN MEDICAL TREATMENT GUIDELINES, TOPICAL ANALGESICS,

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines , 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. In addition, there is no evidence within the medical records submitted that substantiates the necessity of a transdermal versus oral route of administration. Therefore FluriFlex 15/10% 180gm cream to apply a thin to affected area twice daily as directed by physician cannot be recommended as medically necessary as it does not meet established and accepted medical guidelines.

TGICE 8/10/2/2% 180GM CREAM TO APPLY A THIN TO AFFECTED AREA TWICE DAILY AS DIRECTED BY PHYSICIAN: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: CHRONIC PAIN MEDICAL TREATMENT GUIDELINES, TOPICAL ANALGESICS,

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

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. In addition, there is no evidence within the medical records submitted that substantiates the necessity of a transdermal versus oral route of administration. Therefore TGIce 8/10/2/2% 180GM cream to apply a thin to affected area twice daily as directed by physician cannot be recommended as medically necessary as it does not meet established and accepted medical guidelines.

RETROSPECTIVE REVIEW FOR URINALYSIS: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: CHRONIC PAIN MEDICAL TREATMENT GUIDELINES, OPIOIDS, SCREENING FOR RISK OF ADDICTION (TESTS),

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Drug testing Page(s): 43.

Decision rationale: As noted on page 43 of the Chronic Pain Medical Treatment Guidelines, urine drug screens are recommended as an option to assess for the use or the presence of illegal drugs. Additionally, they can be used to detect the presence of drug dependence or diversion. However, there is no indication in the documentation of suspicion of diversion, dependence, or

the use of opioid medications. The injured worker can be monitored on a quarterly or biannual basis. As such, the retrospective review for urinalysis cannot be recommended as medically necessary at this time.