

<b>Case Number:</b>	CM14-0102562		
<b>Date Assigned:</b>	07/30/2014	<b>Date of Injury:</b>	10/05/2006
<b>Decision Date:</b>	09/10/2014	<b>UR Denial Date:</b>	06/23/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/02/2014

### 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 Physical Medicine and Rehabilitation, has a subspecialty in Pain Medicine and is licensed to practice in Texas and Oklahoma. 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 56-year-old female who reported an injury on 10/05/2006. The mechanism of injury was not specifically stated. The current diagnoses include cervical spine discopathy, left shoulder mild acromioclavicular joint arthropathy, lumbar spine discopathy, right knee internal derangement, morbid obesity, and status post gastric bypass surgery. The injured worker was evaluated on 01/03/2014 with complaints of ongoing pain in the neck, back, and right knee. The injured worker also reported spasm, difficulty sleeping, and considerable weakness. Physical examination on that date revealed an antalgic gait, tenderness over the paraspinous musculature of the cervical region on the right, midline cervical tenderness, positive muscle spasm, limited cervical range of motion, limited lumbar range of motion, tenderness over the paraspinous musculature of the lumbar region, positive muscle spasm in the lumbar spine, decreased sensation in the right L5-S1 dermatome, tenderness over the medial and lateral aspect of the right knee, positive McMurray's testing, positive patellar grind maneuver, hamstring tenderness, limited right knee range of motion, and diminished strength. It is noted that the injured worker has been previously treated with psychotherapy and psychotropic medication. Treatment recommendations at that time included continuation of Norco, tramadol ER, and transdermal creams. A Request for Authorization was then submitted on 01/03/2014 for Norco 10/325 mg, #60, Tramadol ER 200 mg, #60, Fluriflex cream, and TG Hot cream.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**TGHot Cream 240 gm:** Upheld

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

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

**Decision rationale:** The California MTUS Guidelines state topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. Any compounded product that contains at least 1 drug that is not recommended is not recommended as a whole. Gabapentin is not recommended as there is no peer reviewed literature to support its use as a topical product. There was also no strength or frequency listed in the current request. As such, TGHot Cream 240 gm is not medically necessary.

**Fluriflex Cream 240gm:** Upheld

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

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

**Decision rationale:** The California MTUS Guidelines state topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. Any compounded product that contains at least 1 drug that is not recommended is not recommended as a whole. Cyclobenzaprine is not recommended for topical use. The only FDA approved topical NSAID is diclofenac. There is also no strength or frequency listed in the request. As such, Fluriflex Cream 240gm is not medically necessary.

**Tramadol ER 200mg #60:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 74-82.

**Decision rationale:** The California MTUS Guidelines state a therapeutic trial of opioids should not be employed until the patient has failed a trial of non-opioid analgesics. Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects should occur. There is no documentation of a failure to respond to non-opioid analgesics. There is also no frequency listed in the current request. Therefore, Tramadol ER 200mg #60 is not medically necessary.

**Norco 10/325mg #60:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 74-82.

**Decision rationale:** The California MTUS Guidelines state a therapeutic trial of opioids should not be employed until the patient has failed a trial of non-opioid analgesics. Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects should occur. There is no documentation of a failure to respond to non-opioid analgesics. There is also no frequency listed in the current request. Therefore, the request is not medically appropriate. As such, Norco 10/325mg #60 is not medically necessary.