

Case Number:	CM14-0103467		
Date Assigned:	07/30/2014	Date of Injury:	01/26/2012
Decision Date:	10/06/2014	UR Denial Date:	06/26/2014
Priority:	Standard	Application Received:	07/03/2014

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 Anesthesiology, has a subspecialty in Pain Management 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 44 year old female injured on 01/26/12. The mechanism of injury is a result of cumulative trauma causing shoulder pain. Treatment to date included a left shoulder surgery on 02/24/12 with left shoulder arthroscopic subacromial decompression and distal clavicle excision. The injured worker had subsequent right shoulder surgery on 01/17/14 with arthroscopic debridement, acromioplasty, and lysis of adhesions. Diagnoses include cervical strain/sprain and status post bilateral shoulder arthroscopy with decompression. The clinical note dated 05/13/14 indicated the injured worker presented reporting improved neck pain, bilateral shoulder pain, right greater than left. The injured worker reported axial pain in the neck very tolerable following shoulder surgery. Physical examination of the cervical spine revealed slight muscular tension throughout the cervical spine as well as axial tenderness, shoulders revealed healed arthroscopic portals on the bilateral shoulders, right shoulder with some painful range of motion, left shoulder good range of motion, and only limited amount of pain. Treatment plan included continuation of a home exercise program, prescription for Ibuprofen 800 milligrams twice daily as needed twice daily as needed with two refills, Fluoroflex, and TG ICE. The initial request for Ibuprofen, Fluoroflex, TG ICE, and a follow up consultation for pain medicine was initially noncertified on 06/25/14.

IMR ISSUES, DECISIONS AND RATIONALES

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

IBUPROFEN 800MG #60 WITH 2 REFILLS: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines ANTI- INFLAMMATORY MEDICATIONS Page(s): 22.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, specific drug list & adverse effects Page(s): 70.

Decision rationale: As noted in the Chronic Pain Medical Treatment Guidelines, non-steroidal anti-inflammatory drugs (NSAIDs) are recommended as a second line treatment after acetaminophen for acute exacerbations of chronic pain. In general, there is conflicting evidence that NSAIDs are more effective than acetaminophen for acute lower back pain. Additionally, it is generally recommended that the lowest effective dose be used for all NSAIDs for the shortest duration of time. Further, there is no indication the injured worker cannot utilize the readily available over the counter formulation and similar dosage of this medication when required on an as needed basis. As such, the request for Ibuprofen 800 milligrams quantity sixty with two refills cannot be established as medically necessary.

FLURIFLEX: Upheld

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

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

Decision rationale: As noted in 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. Further, California Medical Treatment Utilization Schedule (MTUS), Food and Drug Administration, and Official Disability Guidelines require that all components of a compounded topical medication be approved for transdermal use. Fluriflex contains Flurbiprofen and Cyclobenzaprine which have not been 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. Fluriflex cannot be recommended as medically necessary.

CONTINUE TGICE: Upheld

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

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

Decision rationale: As noted in 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. Further, California Medical Treatment Utilization Schedule (MTUS), Food and Drug Administration, and Official Disability Guidelines require that all components of a compounded topical medication be approved for transdermal use. TG Ice contains multiple components which have not been 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. TG Ice cannot be recommended as medically necessary.

FOLLOW UP CONSULT WITH PAIN MANAGEMENT: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines PART 1 , INTRODUCTION Page(s): 1.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines online version, Low back Complaints

Decision rationale: As noted in the low back complaints section of California Medical Treatment Utilization Schedule (MTUS), follow up evaluations should occur no later than one week into the acute pain period. American College of Occupational and Environmental Medicine (ACOEM) indicates, at the other extreme, in the stable chronic low back pain (LBP) setting, follow up may be infrequent, such as every six months. There is no indication in the documentation that the injured worker has had a significant alteration in status, acute injury, or requires treatment out of the scope of the primary care provider. Additionally, the request did not specify the intent for referral and issues to be addressed. As such, the request for follow up consult with pain management cannot be recommended as medically necessary at this time.