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| <b>Case Number:</b>   | CM14-0109317 |                              |            |
| <b>Date Assigned:</b> | 08/01/2014   | <b>Date of Injury:</b>       | 10/05/2006 |
| <b>Decision Date:</b> | 10/09/2014   | <b>UR Denial Date:</b>       | 06/27/2014 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 07/14/2014 |

### 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 & Rehabilitation and is licensed to practice in Nevada. 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 was reportedly injured on October 5, 2006. The mechanism of injury was not listed in the records reviewed. The most recent progress note dated June 17, 2014, indicates that there are ongoing complaints of low blood sugar, nausea, and reflux symptoms. The physical examination demonstrated abdominal tenderness in the mid-epigastric region. There was bilateral ankle edema and synovitis in both hands. A Tinel's sign at the wrist was positive. Diagnostic imaging studies were not reviewed during this visit. Previous treatment includes oral and topical medications. A request was made for Ultram, Norco, Fluriflex cream, TG hot cream and Omeprazole and was not certified in the pre-authorization process on June 27, 2014.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Ultram 50mg #60, with 2 refills DOS 04/25/14: Upheld**

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

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

**Decision rationale:** The California Medical Treatment Utilization Schedule guidelines support the use of tramadol (Ultram) for short-term use after there is been evidence of failure of a first-line option, evidence of moderate to severe pain, and documentation of improvement in function with the medication. A review of the available medical records fails to document any improvement in function or pain level with the previous use of Tramadol. As such, the request is not considered medically necessary.

**Norco 10/325mg #90 with 1 refill DOS 04/25/14: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 74-78, 88, 91.

**Decision rationale:** Norco (Hydrocodone/acetaminophen) is a short acting opiate indicated for the management in controlling moderate to severe pain. This medication is often used for intermittent or breakthrough pain. The California Medical Treatment Utilization Schedule guidelines support short-acting opiates at the lowest possible dose to improve pain and function, as well as the ongoing review and documentation of pain relief, functional status, appropriate medication use and side effects. The injured employee has chronic pain; however, there is no objective clinical documentation of improvement in their pain or function with the current regimen. As such, this request for Norco is not medically necessary.

**FluriFlex cream 240gm DOS 04/25/14: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111-112.

**Decision rationale:** Fluriflex cream is a topical compound consisting of Flurbiprofen and Cyclobenzaprine. California Medical Treatment Utilization Schedule Chronic Pain Guidelines state that topical analgesics are "largely experimental" and "any compound product that contains at least one drug (or drug class) that is not recommended is not recommended". The guidelines note there is little evidence to support the use of topical non-steroidal anti-inflammatory drugs (Flurbiprofen) for treatment of osteoarthritis of the spine, hip or shoulder and there is no evidence to support the use for neuropathic pain. Additionally, the guidelines state there is no evidence to support the use of topical Cyclobenzaprine (a muscle relaxant). The guidelines do not support the use of Flurbiprofen or Cyclobenzaprine in a topical formulation. Therefore, the request for FluriFlex cream is not medically necessary.

**TGHot cream 240gm DOS 04/25/14: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111-112.

**Decision rationale:** TGHot is a compound of Tramadol, Gabapentin, Menthol and Camphor. The California Medical Treatment Utilization Schedule Chronic Pain Guidelines state that topical analgesics are "largely experimental" and "any compound product that contains at least one drug (or drug class) that is not recommended is not recommended". The guidelines indicate gabapentin is not recommended for topical application. Additionally, the guidelines recommend the use of capsaicin only as an option for patients who are intolerant of other treatments and there is no indication that an increase over a 0.025% formulation would be effective. There is no documentation in the records submitted indicating the injured worker was intolerant of other treatments. The request for topical TGHot is not in accordance with the California Medical Treatment Utilization Schedule guidelines. Therefore, the request for TGHot Cream is not medically necessary.

**Omeprazole 20mg #60 with 1 refill DOS 04/25/14: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) -TWC, Pain Procedure Summary

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 68.

**Decision rationale:** Prilosec (Omeprazole) is a proton pump inhibitor useful for the treatment of gastroesophageal reflux disease (GERD) and is considered a gastric protectant for individuals utilizing non-steroidal anti-inflammatory medications. There is no indication in the record provided of a gastrointestinal disorder. Additionally, the injured employee does not have a significant risk factor for potential gastrointestinal complications as outlined by the California Medical Treatment Utilization Schedule. Therefore, this request for Prilosec is not medically necessary.