

<b>Case Number:</b>	CM14-0015538		
<b>Date Assigned:</b>	02/28/2014	<b>Date of Injury:</b>	02/09/2011
<b>Decision Date:</b>	07/08/2014	<b>UR Denial Date:</b>	01/23/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/06/2014

### 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 Sports Medicine, 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 56-year-old who reported an injury on February 9, 2011; the mechanism of injury was not provided within the submitted medical records. Within the clinical note dated December 30, 2013, the injured worker complained of persistent left shoulder pain, rated 6/10. She also complained of severe low back pain rated 8/10 with constant radiating pain to the lower extremities. The note further revealed that the injured worker was utilizing Norco which was helping alleviate her pain. The physical exam revealed the left shoulder had joint tenderness along the posterior acromioclavicular joint with limited range of motion. The exam of the lumbar spine revealed spasms and tenderness along the paraspinal muscles. The injured worker also had a positive straight leg raise test bilaterally with an antalgic gait. The injured worker's diagnoses include right hip tendonitis, right hip bursitis, right sided L5-S1 lumbar radiculopathy, L3-4 and L4-5 annular tearing, left shoulder impingement, and gastrointestinal pain. The request for authorization was dated December 30, 2013 for mitigation of pain.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**PRESCRIPTION OF FLURFLEX 180GM (FLURBIPROFEN 15%  
CYCLOBENZAPRINE 10%) APPLY A THIN LAYER TO AFFECTED AREA TWICE  
DAILY:** Upheld

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

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

**Decision rationale:** The Chronic Pain Medical Treatment Guidelines state that any compounded product that contains at least one drug that is not recommended the entire compound is not recommended. Furthermore, the guidelines state the indicated usage of topical NSAIDs (non-steroidal anti-inflammatory drugs) is for osteoarthritis and tendonitis, in particular, that of the knee and elbow or other joints that are amenable to topical treatment are recommended for short-term use (four to twelve weeks). The guidelines also state there is little evidence to utilize topical NSAIDs for the treatment of osteoarthritis of the spine, hip, or shoulder. Additionally, the guidelines indicate that topical muscle relaxants show no evidence for use. Given the active ingredients for FluriFlex 180 g is Flurbiprofen 15% and cyclobenzaprine 10%, both of the primary ingredients are contraindicated by the guidelines, and as such cannot be supported at this time. The request for one prescription of Flurflex 180gm (flurbiprofen 15%/cyclobenzaprine 10%) is not medically necessary or appropriate.

**PRESCRIPTION OF TGICE 180GM (TRAMADOL 8% GABAPENTIN 10% MENTHOL 2% CAMPHOR 2%) APPLY A THIN LAYER TO AFFECTED AREA TWICE DAILY:** Upheld

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

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

**Decision rationale:** The Chronic Pain Medical Treatment Guidelines state that any compounded product that contains at least one drug that is not recommended is (as a whole) is not recommended. Additionally, the guidelines state that gabapentin as a topical analgesic is not recommended due to the fact there is no peer reviewed literature to support its use. Given the primary ingredients of TGIce 180 g are tramadol 8%, gabapentin 10%, menthol 2%, and camphor 2%, and since one or more of the primary compounded ingredients is not recommended by the guidelines, the request cannot be supported at this time. The request for one prescription of TGIce 180gm (tramadol 8%/gabapentin 10%/menthol 2%/camphor 2%) is not medically necessary or appropriate.