

<b>Case Number:</b>	CM14-0015824		
<b>Date Assigned:</b>	03/03/2014	<b>Date of Injury:</b>	09/02/2009
<b>Decision Date:</b>	08/04/2014	<b>UR Denial Date:</b>	01/23/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/07/2014

### 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 and is licensed to practice in California. 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 patient is a 52-year-old female who has submitted a claim for C5-C6 disc herniation with upper extremity radiculopathy, bilateral upper extremity overuse tendinopathy, right shoulder impingement syndrome, and L4-L5 disc protrusion with right-sided radiculopathy; associated with an industrial injury date of 10/02/2009. Medical records from 10/12/2012 to 12/16/2013 were reviewed and showed that patient complained of persistent neck and right upper extremity pain, associated with constant headaches. Physical examination showed tenderness over the trapezius, cervical spine, and anterior acromioclavicular joint. Spasms were also noted. Range of motion of the right shoulder was limited. Impingement sign was mildly positive. Motor and sensory testing findings were not provided. Treatment to date has included medications, ESWT, physical therapy, chiropractic therapy, and Toradol injection. Utilization review, dated 01/23/2014, denied the request for Fluriflex cream because guidelines do not recommend its use; and denied the request for Toradol injection because documentation does not indicate that patient has pain with elevation that significantly limits her activities following conservative treatment.

### IMR ISSUES, DECISIONS AND RATIONALES

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

#### **FLURIFLEX FLURBIPROFEN/CYCLOBENZAPRINE 15/10% CREAM 180GM:**

Upheld

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

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

**Decision rationale:** As stated on pages 112 to 113 of the CA MTUS Chronic Pain Medical Treatment Guidelines, topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. They are recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Regarding the flurbiprofen component, guidelines state that topical NSAIDs are not recommended for neuropathic pain as there is no evidence to support use. Regarding the cyclobenzaprine component, there is no evidence for use muscle relaxants as a topical product. Guidelines state that any compounded product that contains a drug class that is not recommended is not recommended. In this case, the patient has been prescribed Fluriflex cream since at least October 2013 because of acid reflux associated with oral medications. However, there is no objective functional improvement from its use. Furthermore, guidelines do not recommend the topical use of cyclobenzaprine and flurbiprofen. Therefore, the request for Fluriflex Flurbiprofen/Cyclobenzaprine 15/10% cream 180gm is not medically necessary.

**TGICE TRAMADOL/GABAPENTIN/MENTHOL/CAMPHOR 8/10/2/2% CREAM 180GM:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines : Topical analgesics Page(s): 111-113. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Topical Salicylates.

**Decision rationale:** TGIce contains Tramadol, Gabapentin, Menthol, and Camphor. Pages 111-113 of the CA MTUS Chronic Pain Medical Treatment Guidelines state that topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. Topical analgesics are recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. There is little to no research to support the use of many these agents. The topical formulation of tramadol does not show consistent efficacy. In addition, Chronic Pain Medical Treatment Guidelines state that gabapentin is not recommended for topical applications. Regarding the Menthol component, CA MTUS does not cite specific provisions, but the Official Disability Guidelines states that the FDA issued a safety warning which identifies rare cases of serious burns that have been reported to occur on the skin where menthol, methyl salicylate, or capsaicin were applied. The guidelines do not address camphor. In this case, the patient has been prescribed TGIce cream since at least October 2013 because of acid reflux associated with oral medications. However, there is no objective functional improvement from its use. Furthermore, guidelines state that any compounded product that contains a drug class that is not recommended is not recommended. TGIce cream contains drug components that are not recommended for topical use. Therefore, the request for TGICE is not medically necessary.

**INTRAMUSCULAR INJECTION OF TORADOL, RETROSPECTIVE:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Toradol.

**Decision rationale:** The CA MTUS does not address this topic. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, Official Disability Guidelines (ODG) was used instead. ODG states that Toradol injection is recommended as an option to corticosteroid injections, with up to three injections. When administered intramuscularly, may be used as an alternative to opioid therapy. In this case, the patient complains of neck and upper extremity pain. The medical records submitted for review showed no evidence of intolerance to opioid medications. Moreover, there was no evidence regarding the severity of pain (i.e., the VAS score) to warrant analgesia using intramuscular injections. Lastly, the present request as submitted failed to specify the date of service to be reviewed. Therefore, the request for intramuscular injection of toradol, retrospective is not medically necessary.