

Case Number:	CM14-0016153		
Date Assigned:	03/05/2014	Date of Injury:	02/01/1995
Decision Date:	05/28/2014	UR Denial Date:	01/24/2014
Priority:	Standard	Application Received:	02/09/2014

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 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 60-year-old male who reported an injury on 02/01/1995. The mechanism of injury was not stated. The current diagnoses include cervical discopathy, mild cervical radiculopathy, left shoulder impingement, bilateral upper extremity overuse tendonitis, mild carpal tunnel syndrome, lumbar discopathy, lumbar spondylolisthesis and lumbar radiculopathy. The injured worker was evaluated on 12/30/2013. The injured worker reported ongoing pain in the lower back with an increase in pain in the left shoulder. Physical examination revealed tenderness at the acromioclavicular joint of the left shoulder, decreased grip strength, painful range of motion, tenderness and spasm in the lumbar spine, limited range of motion, an antalgic gait, weakness and decreased sensation in the L5 and S1 dermatomes. The treatment recommendations included prescriptions for Norco 10/235 mg, Flurflex cream, and TG Ice cream.

IMR ISSUES, DECISIONS AND RATIONALES

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

NORCO 10/325MG #120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 78 and 91.

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

Decision rationale: The California MTUS Guidelines state that 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. The injured worker has utilized Norco 10/325 mg since 09/2013. There is no documentation of objective functional improvement. The injured worker continues to report ongoing left shoulder and lower back pain despite the ongoing use of this medication. There was also no frequency listed in the current request. Therefore, the request is non-certified.

FLURIFLEX CREAM 180GM: Upheld

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

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

Decision rationale: The California MTUS Guidelines state that topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. The MTUS states that any compounded product that contains at least 1 drug that is not recommended is not recommended as a whole. Flexeril is not recommended as there is no evidence for the use of any muscle relaxant as a topical product. Therefore, the request is not medically appropriate. There is also no frequency listed in the current request. As such, the request is non-certified.

TG ICE CREAM 180GM: Upheld

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

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

Decision rationale: The California MTUS Guidelines state that topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. Gabapentin is not recommended as there is no evidence for the use of any anti-epilepsy drug as a topical product. There was also no frequency listed in the current request. Therefore, the request is non-certified.