

Case Number:	CM14-0116550		
Date Assigned:	08/04/2014	Date of Injury:	10/02/2001
Decision Date:	09/22/2014	UR Denial Date:	07/03/2014
Priority:	Standard	Application Received:	07/24/2014

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 Pain Medicine 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 67-year-old male who reported an injury 10/02/2001. The Mechanism of injury was not provided within the medical records. The clinical note dated 06/10/2014 indicated diagnoses of left rotator cuff syndrome, lumbar spine spondylosis, lumbar spine herniated nucleus pulposus, sciatica, status post left total knee arthroplasty, knee osteoarthritis/degenerative joint disease, left knee effusion, bilateral lower extremity radiculitis, and diabetes for more than 25 years. The injured worker reported left shoulder pain, low back pain, and left knee pain rated 8/10. The injured worker reported pain, numbness, and tingling along the posterior left lower extremity and to the great toe and 2nd toe. He reported increased numbness of the great toe and 2nd toe. The injured worker reported low back pain that awoke him at night. The injured worker reported difficulty with ambulation. The injured worker reported he fell and struck the commode, striking his left shoulder. The injured worker reported difficulties with activities of daily living to include getting in and out of bed, cooking, cleaning and bathing. Upon physical examination of the lumbar spine, there was tenderness over the paralumbar muscles bilaterally. Range of motion was decreased and limited by pain in all directions. There were spasms upon flexion of the lumbar spine. The injured worker's Kemp's test was positive bilaterally, straight leg testing was positive bilaterally at 30 degrees. The injured worker's shoulder examination revealed tenderness over the rotator cuff expense of the left shoulder. The injured worker's range of motion was decreased and limited upon flexion, extension, and internal/external rotation. The injured worker had a positive impingement and empty can supraspinatus test. The injured worker's knee examination revealed tenderness over the peripatellar area of the left knee with decreased range of motion upon flexion at 95 degrees with pain upon flexion and extension of the left knee. The injured worker's upper extremity

motor exam was decreased and the injured worker's lower extremity deep tendon reflexes were decreased bilaterally. The injured worker's treatment plan included consultation for orthopedic followup, diagnostic ultrasound of the left knee, continued pain management. The injured worker's prior treatments included diagnostic imaging, surgery, and medication management. The injured worker's medication regimen included tramadol and Fentanyl. The provider submitted a request for TGHOT, Fluriflex and neurological consultation. A Request for Authorization dated 06/10/2014 was submitted for the above; however, a rationale was not provided for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

TGHOT cream 180gm: Upheld

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

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

Decision rationale: The request for TGHOT cream 180gm is not medically necessary. TGHOT contains (capsaicin, menthol, camphor). The California MTUS guidelines indicate that topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. Primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. The guidelines also state any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. It was not indicated if the injured worker had tried and failed other antidepressants or anticonvulsants. In addition, it was not indicated if the injured worker responded or was intolerant to other treatments. Furthermore, the provider did not indicate a rationale for the request. Additionally, the request does not indicate a quantity or frequency for the TGHOT cream. Therefore, the TGHOT cream 180gm is not medically necessary.

FlurFlex 180g: Upheld

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

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

Decision rationale: The request for FlurFlex Cream is not medically necessary. Fluriflex (flubiprofen/cyclobenzaprine 15/10%). The California Chronic Pain Medical Treatment Guidelines state that transdermal compounds are largely experimental in use with few randomized controlled trials to determine efficiency or safety. It is primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Many agents are compounded as monotherapy or in combination for pain control, including NSAIDs, opioids,

capsaicin, local anesthetics, antidepressants, glutamate receptor antagonists, -adrenergic receptor agonist, adenosine, cannabinoids, cholinergic receptor agonists, agonists, prostanoids, bradykinin, adenosine triphosphate, biogenic amines, and nerve growth factor. There is little to no research to support the use of many of these agents. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Cyclobenzaprine is not recommended. The guidelines indicate there is no evidence for use of any other muscle relaxant as a topical product. Per the guidelines, any compounded product that at least drug, or drug class, that is not recommended is not recommended. Moreover, the request does not indicate a frequency or quantity for the Flurflex. Additionally, the provider did not indicate a rationale for the request. Therefore, the request for FluriFlex Cream is not medically necessary.

Neurological consultation: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: American College of Occupational and Environmental Medicine (ACOEM), updated guidelines, Chapter 6, page 163.

Decision rationale: The request for Neurological consultation is not medically necessary. The American College of Occupational and Environmental Medicine Guidelines state that a consultation is intended to aid in assessing the diagnosis, prognosis, therapeutic management, determination of medical stability, and permanent residual loss and/or examinee's fitness for return to work. It is not indicated how a neurological exam would aid in a provider's determination of prognosis, therapeutic management, or determination of medical stability for the injured worker. In addition, the provider did not indicate a rationale for the request. Therefore, the request for Neurological consultation is not medically necessary.