

Case Number:	CM14-0152242		
Date Assigned:	09/22/2014	Date of Injury:	01/01/2006
Decision Date:	10/22/2014	UR Denial Date:	09/09/2014
Priority:	Standard	Application Received:	09/18/2014

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 Occupational Medicine 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:

This is a 56-year-old female with a 1/1/06 date of injury, when she sustained injuries to the bilateral wrists and the right shoulder during the performance of her routine and customary job duties as a bus driver. The patient underwent right upper extremity surgery on 12/28/10. The patient was seen on 2/19/14 with complaints of soreness in the left shoulder. Exam findings of the left shoulder revealed: flexion 170 degrees, extension 50 degrees, adduction 30 degrees, abduction 160 degrees, internal rotation 70 degrees and external rotation 80 degrees. The diagnosis is sprain of the shoulder and rotator cuff, muscle spasm, carpal tunnel syndrome, degenerative joint disease. Treatment to date: physical therapy, work restrictions and medications. An adverse determination was received on 9/9/14 given that the rationale for the request was incomplete. The submitted documentation only indicted that the patient reported pain relief with the use of medications.

IMR ISSUES, DECISIONS AND RATIONALES

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

Flurido-A cream #240: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics regarding Non-Steroidal Anti-Inflammatory Agent.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Capsaicin, Topical Analgesics Page(s): 25,28,111-113.

Decision rationale: CA MTUS and ODG do not address Flurido-A cream. Chronic Pain Medical Treatment Guidelines state that topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. Medication 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 these agents. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. The ingredients of Flurido A cream are unknown and there is a lack of documentation indicating that the patient was using the cream in the past. In addition, there is no rationale with regards to the need for that cream, there are no clearly specified goals with the treatment and the area of application was not indicated. Therefore, the request for Flurido-A cream #240 was not medically necessary.

Ultraflex-G Cream #240: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics regarding Non-Steroidal Anti-Inflammatory Agent.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Capsaicin, Topical Analgesics Page(s): 25, 28,111-113..

Decision rationale: CA MTUS and ODG do not address Ultraflex- G cream. Chronic Pain Medical Treatment Guidelines state that topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. Medication 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 these agents. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. The ingredients of Ultraflex G cream are unknown and there is a lack of documentation indicating that the patient was using the cream in the past. In addition, there is no rationale with regards to the need for that cream, there are no clearly specified goals with the treatment and the area of application was not specified. Therefore, the request for Ultraflex G cream #240 was not medically necessary.