

Case Number:	CM14-0030586		
Date Assigned:	06/20/2014	Date of Injury:	12/05/2010
Decision Date:	07/18/2014	UR Denial Date:	02/18/2014
Priority:	Standard	Application Received:	03/11/2014

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 Anesthesiology, has a subspecialty in Pain 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:

The injured worker is a 35 year-old female injured on 12/05/10 due to an undisclosed mechanism of injury. Current diagnoses include impingement of the left shoulder, status post lateral release of the right elbow and carpal tunnel syndrome bilaterally. Clinical note dated 2/6/14 indicates the injured worker presented complaining of low back pain, right elbow pain, bilateral wrist pain with associated tingling and numbness and left hip pain rated at 5-9/10. Objective findings include positive apprehension test, positive Neers sign, positive Hawkins sign to the left shoulder, positive Tinel's test left elbow, and positive Phalen's right wrist. Medications include cyclobenzaprine 7.5 mg, Dyotin 50 mg, Flurbitac 100/100 mg, Theraflex cream, Keratek gel, and Vicosetron 10/300/2 mg. initial request were noncertified on 2/18/14.

IMR ISSUES, DECISIONS AND RATIONALES

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

Prescription of Cyclobenzaprine 7.5mg: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants (for pain) Page(s): 67.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 9792.20, Cyclobenzaprine Page(s): 41.

Decision rationale: Cyclobenzaprine is recommended as a second-line option for short-term (less than two weeks) treatment of acute low back pain and for short-term treatment of acute exacerbations in patients with chronic low back pain. Studies have shown that the efficacy appears to diminish over time, and prolonged use of some medications in this class may lead to dependence. Based on the clinical documentation, the injured worker has exceeded the 2-4 week window for acute management also indicating a lack of efficacy if being utilized for chronic flare-ups. Additionally, the physical examination failed to provide objective findings significant for spasm necessitating the use of muscle relaxants. The medical necessity of cyclobenzaprine 7.5mg is not medically necessary at this time.

Prescription of Flurbitac 100/100mg capsule (flurbiprofen): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS. Decision based on Non-MTUS Citation <http://www.rxlist.com/ansaid-drug.htm>.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 9792.20, Topical analgesics Page(s): 111.

Decision rationale: The safety and efficacy of compounded medications has not been established through rigorous clinical trials. Topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. There is no indication in the documentation that these types of medications have been trialed and/or failed. California Medical Treatment Utilization Schedule guidelines, Food and Drug Administration, and Official Disability Guidelines require that all components of a compounded topical medication be approved for transdermal use. Flurbiprofen has not been approved for transdermal use. In addition, there is no evidence within the medical records submitted that substantiates the necessity of a transdermal versus oral route of administration. Therefore Flurbitac 100/100mg capsule (flurbiprofen) cannot be recommended as medically necessary as it does not meet established and accepted medical guidelines.

Prescription of Theraflex transdermal cream 20% 10% 5% (flurbiprofen): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 117-119.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

Decision rationale: The safety and efficacy of compounded medications has not been established through rigorous clinical trials. Topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. There is no indication in the documentation that these types of medications have been trialed and/or failed. California Medical Utilization Schedule guidelines, Food and Drug Administration, and Official Disability Guidelines require that all components of a compounded topical medication be approved for transdermal use. Flurbiprofen has not been approved for transdermal use. In addition, there is no evidence within the medical records submitted that substantiates the necessity of a transdermal versus oral route of administration. Therefore Theraflex transdermal

cream 20% 10% 5% (flurbiprofen) cannot be recommended as medically necessary as it does not meet established and accepted medical guidelines.

Prescription of Keratek gel 4oz: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 117-119.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 9792.20, Salicylate topicals Page(s): 105.

Decision rationale: The safety and efficacy of compounded medications has not been established through rigorous clinical trials. Keratek is noted to contain menthol and methyl salicylate. Topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. There is no indication in the documentation that these types of medications have been trialed and/or failed. Additionally, the components of this compound are readily available in an over-the-counter formulation. As such, Keratek gel 4oz is not medically necessary as it does not meet established and accepted medical guidelines.

Prescription of Vicosetron capsules 10/300/2mg (hydrocodone): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Hydrocodone/APAP Page(s): 82-88.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for Use of Opioids Page(s): 77.

Decision rationale: Patients must demonstrate functional improvement in addition to appropriate documentation of ongoing pain relief to warrant the continued use of narcotic medications. There is no clear documentation regarding the functional benefits or any substantial functional improvement obtained with the continued use of narcotic medications. Additionally, compounded medications are not recommended for use. As such, the request for Vicosetron capsules 10/300/2mg (hydrocodone) cannot be recommended as medically necessary.