

Case Number:	CM14-0050902		
Date Assigned:	07/07/2014	Date of Injury:	04/10/2013
Decision Date:	09/09/2014	UR Denial Date:	03/28/2014
Priority:	Standard	Application Received:	04/18/2014

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 Physical Medicine and Rehabilitation and is licensed to practice in Texas and Ohio. 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 47-year-old male who reported an injury on 04/10/2013. The injured worker's diagnosis was noted to be Olecranon bursitis of the left elbow. It was noted that the injured worker had subjective complaints of pain in his left elbow. He stated that the pain was a mild throbbing pain and an 8 /10 in severity. The objective findings included worsening pain and tenderness to the left elbow since the last office visit. 3 X-rays of the left elbow and 2 full arm X-rays noted no increase of osteoarthritis. The treatment plan was for medication. The provider's rationale for the request was noted within the review. A Request for Authorization form was not provided within the documentation for this request.

IMR ISSUES, DECISIONS AND RATIONALES

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

Compound - flurbiprofen/cyclobenzaprine/menthol c/pentranvan, 30 day supply QTY: 180 with 11 refills: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-112.

Decision rationale: The California MTUS Chronic Pain Medical Treatment Guidelines state topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. These are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. The guidelines state there is little to no research to support the use of compounded drugs, topically. Any compounded product that contains at least 1 drug (or drug class) that is not recommended is not recommended. The documentation provided does not indicate a failed trial of antidepressants or anticonvulsants. The guidelines do not recommend a topical muscle relaxant such as cyclobenzaprine. Therefore, the entire topical cream is not recommended. The provider's request fails to indicate the percentages of each medication within the cream. Therefore, the request for compound - flurbiprofen/cyclobenzaprine/menthol c/pentranvan, 30 day supply, quantity 180, with 11 refills is non-certified.