

Case Number:	CM14-0052675		
Date Assigned:	07/07/2014	Date of Injury:	02/11/2002
Decision Date:	08/11/2014	UR Denial Date:	04/11/2014
Priority:	Standard	Application Received:	04/21/2014

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. 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 55-year-old male injured on 02/11/02 when the vehicle flipped over and the injured worker was knocked unconscious. The injured worker required open reduction internal fixation for fracture of the wrist on 02/14/02 followed by left L4-5 laminotomy and facetectomy with microdiscectomy. Clinical note dated 04/03/14 indicated the injured worker presented complaining of slight to moderate frequent low back pain which increased with activity. Objective findings included lumbar spine tenderness to palpation over paraspinal muscles with tenderness to palpation over left buttocks, positive left straight leg raise, strength 4/5 in left lower extremity, reflexes 2+, and sensation intact throughout bilateral lower extremities. Current medications included Voltaren XR #60 twice a day, Genicin #90 three times a day, flurbi (NAP) cream-LA180g, and Somnicin #30 one PO by mouth every night. The initial request for flurbi (NAP) cream-LA180g and Somnicin #30 was non-certified on 04/11/14.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 Prescription of Flurbi (NAP) cream - LA 180gm: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines; Topical NSAIDs (Non-steroidal antiinflammatory agents (NSAIDs)).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 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. Further, California Medical Treatment Utilization Schedule, Food and Drug Administration and Official Disability Guidelines require that all components of a compounded topical medication be approved for transdermal use. In addition, a frequency and number of refills was not provided with the request. Therefore Flurbi (NAP) cream - LA 180gm cannot be recommended as medically necessary as it does not meet established and accepted medical guidelines.

1 Prescription of Somnich #30: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain (Chronic), Herbal medicines.

Decision rationale: As noted in the Pain chapter of the Official Disability Guidelines - Online version, the use of herbal medicines or medical foods is not recommended. It is believed that the request for Somnich # 30 refers to Somnicin intended for use in management of sleep disorders. The request lacks a frequency and number of refills limiting the ability to review the medication appropriately. As such, the request for Somnich #30 cannot be recommended as medically necessary.