

Case Number:	CM14-0058797		
Date Assigned:	07/09/2014	Date of Injury:	08/26/1996
Decision Date:	09/26/2014	UR Denial Date:	03/25/2014
Priority:	Standard	Application Received:	04/29/2014

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:

Patient is a 73-year-old female who has submitted a claim for right knee medial meniscal tear, right hand strain, right shoulder impingement syndrome, left shoulder impingement, possible rotator cuff tear, and lumbosacral pain associated with an industrial injury date of 8/26/1996. Medical records from 2013 to 2014 were reviewed. Patient complained of low back pain, graded 5/10 in severity, associated with bilateral lower extremity weakness. Patient likewise complained of right knee pain aggravated with weight-bearing. Physical examination showed that patient's height is 5'6", weight of 186 pounds, and derived body mass index of 30 kg/m². Lumbar range of motion was restricted and painful. Sciatic stretch test was positive bilaterally. Sensation was diminished at L4 to S1 dermatomes bilaterally. Lower extremity reflexes were 1+. Weakness of ankle muscles was noted. McMurray's test was positive at right knee with noted abnormal patellar grinding. Gait was antalgic. The requested additional aqua therapy sessions is to strengthen and to improve range of motion of the lower extremities. Treatment to date has included aqua therapy, and medications such as tramadol, Norco, and transdermal creams. Utilization review from 3/25/2014 denied the request for Aqua therapy; twelve (12) sessions (2x6) because of no documented objective and functional gains from prior treatment; and denied the request for Fluriflex 15/10% 180gm cream and TGHOT 8/10/2/2/.05% 180gm cream because of lack of published studies concerning its efficacy and safety.

IMR ISSUES, DECISIONS AND RATIONALES

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

Aqua therapy; twelve (12) sessions (2x6): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Aquatic Therapy Page(s): 22-23.

Decision rationale: As stated on pages 22-23 of the California MTUS Chronic Pain Medical Treatment Guidelines, aquatic therapy is recommended as an alternative to land-based physical therapy where reduced weight bearing is desirable such as extreme obesity or fractures of the lower extremity. In this case, patient has completed a course of aquatic therapy previously. However, the exact number of treatment sessions completed and functional outcomes were not documented. Patient has a body mass index of 30 kg/m²; hence, she is not extremely obese. No fracture of the lower extremity was likewise noted. Furthermore, there was no indication why the patient could not participate in a land-based physical therapy program. Therefore, the request for Aqua therapy; twelve (12) sessions (2x6) is not medically necessary.

Fluriflex 15/10% 180gm cream: Upheld

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

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

Decision rationale: Fluriflex contains flurbiprofen 10% and cyclobenzaprine 10%. According to CA MTUS Chronic Pain Medical Treatment Guidelines pages 111-113, topical analgesics are largely experimental in use with few randomized controlled trials to determine safety or efficacy. Cyclobenzaprine is not recommended for use as a topical analgesic. In addition, there is little to no research as for the use of flurbiprofen in compounded products. In this case, patient was prescribed topical products as adjuvant therapy to oral medications. However, the compounded product contains Flurbiprofen and cyclobenzaprine that are not recommended for topical use. Guidelines state that any compounded product that contains a drug class that is not recommended is not recommended. Therefore, the request for Fluriflex 15/10% 180gm cream is not medically necessary.

TGHot 8/10/2/2/.05% 180gm cream: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Capsaicin, Topical Analgesics Page(s): 28-29, 111-113.

Decision rationale: TGHot contains Tramadol, Gabapentin, Menthol, Camphor, and 0.05% Capsaicin. As stated on pages 111-113 of the California MTUS Chronic Pain Medical Treatment

Guidelines, topical analgesics are largely experimental in use with few randomized controlled trials to determine safety or efficacy. The topical formulation of tramadol does not show consistent efficacy. CA MTUS does not support the use of opioid medications and gabapentin in a topical formulation. Regarding the Menthol component, CA MTUS does not cite specific provisions, but the ODG Pain Chapter states that the FDA has issued an alert in 2012 indicating that topical OTC pain relievers that contain menthol, methyl salicylate, or capsaicin, may in rare instances cause serious burns. The guidelines do not address camphor. CA MTUS Chronic Pain Medical Treatment Guidelines identifies on page 28 that topical Capsaicin is only recommended as an option if there was failure to respond or intolerance to other treatments. The guideline states there is no current indication that an increase over a 0.025% formulation of capsaicin would provide any further efficacy. In this case, topical cream is prescribed as adjuvant therapy to oral medications. However, the prescribed medication contains tramadol, gabapentin, and 0.05% capsaicin, which are not recommended for topical use. Guidelines state that any compounded product that contains a drug class that is not recommended is not recommended. Therefore, the request for TGHot 8/10/2/2/.05% 180gm cream is not medically necessary.