

Case Number:	CM14-0072703		
Date Assigned:	07/16/2014	Date of Injury:	05/31/2011
Decision Date:	09/19/2014	UR Denial Date:	04/28/2014
Priority:	Standard	Application Received:	05/19/2014

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 56-year-old female injured on 05/31/11 due to an undisclosed mechanism of injury. Neither the specific injuries sustained nor the initial treatments rendered were discussed in the documents provided. Diagnosis included left knee pes anserinus bursitis. The sole clinical documentation provided was an extracorporeal shockwave procedure report dated 12/17/13. The note indicated the injured worker underwent prior treatment to include medications, physical and manipulative therapy, and injections with continued symptoms to the left knee. The initial request for Retro TGHOT 180gm, daily at night, Retro Motrin 600mg #60, 1 tab p.o. w/meals, daily-BID 1 month, Retro Motrin 600 mg #60, 1 tab p.o. w/meals, daily-BID 1 month, and Fluriflex 180 gm, daily was initially non-certified on 04/28/14.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retro TGHOT 180gm, Q.D. at night: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 112.

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

Decision rationale: As noted on page 111 of the Chronic Pain Medical Treatment Guidelines, 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. This compound is noted to contain Tramadol, gabapentin, Menthol, Camphor, and Capsaicin. There is no indication in the documentation that the injured worker cannot utilize the readily available over-the-counter version of this medication without benefit. As such, the request for TGHOT 180gm, DAILY at night cannot be recommended as medically necessary.

Retro Motrin 600mg #60, 1 tab p.o. w/meals, Q.D.-BID 1 month: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS, specific drug list & adverse effects Page(s): 70.

Decision rationale: As noted on page 70 of the Chronic Pain Medical Treatment Guidelines, NSAIDs are recommended as a second-line treatment after acetaminophen for acute exacerbations of chronic pain. In general, there is conflicting evidence that NSAIDs are more effective than acetaminophen for acute lower back pain. Additionally, it is generally recommended that the lowest effective dose be used for all NSAIDs for the shortest duration of time. Further, there is no indication the injured worker cannot utilize the readily available formulation and similar dosage of this medication when required on an as needed basis. As such, the request for Retro Motrin 600mg #60, 1 tab p.o. w/meals, DAILY-BID 1 month cannot be established as medically necessary.

Fluriflex 180gm, Q.D.: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111, 113.

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

Decision rationale: As noted on page 111 of the Chronic Pain Medical Treatment Guidelines, 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. Further, CAMTUS, Food and Drug Administration, and Official Disability Guidelines require that all components of a compounded topical medication be approved for transdermal use. This compound contains Flurbiprofen and cyclobenzaprine which have 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 Fluriflex 180gm, DAILY cannot be recommended as medically necessary as it does not meet established and accepted medical guidelines.