

Case Number:	CM14-0083673		
Date Assigned:	07/21/2014	Date of Injury:	08/11/2001
Decision Date:	08/29/2014	UR Denial Date:	05/09/2014
Priority:	Standard	Application Received:	06/05/2014

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 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 45 year old female with a reported injury on 05/11/2011. The mechanism of injury was not provided. The injured worker's diagnoses consisted of lumbar sprain/strain, left foot plantar fasciitis, left foot crush syndrome, anxiety and depression, and gastrointestinal disorder. The injured worker had an examination on 04/11/2014, as a follow-up for the injury to her low back and left foot. She continued to have pain and discomfort and returned for the evaluation for a refill of her medications. She rated her back pain at 8/10 and her foot pain at 8/10. She complained of burning pain to her foot. She also complained of stabbing pain to her hips and pain in the groin area on the right and also to the right buttock. The injured worker complained of heartburn, a change in appetite, nausea, a change in bowel habits, rectal bleeding, and constipation. Range of motion to the lumbar spine demonstrated flexion was from 25 to 30 degrees, extension was 20 degrees and her tilt to the right and left was 20 degrees. There was noted motor weakness in the lower extremities. The injured worker had full range of motion to her left ankle and foot. The injured worker was not taking any prescription medications at that time. The physician's treatment plan included recommendations to refer the injured worker to a podiatrist for a consultation for her left foot, attend physical therapy, and use Ultracet, TGHOT cream, and Fluriflex cream. Additionally, the physician recommended the Kronos lumbar support. The Request for Authorization was signed and dated for 04/11/2014 and the rationale was not provided.

IMR ISSUES, DECISIONS AND RATIONALES

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

Kronos Lumbar Support: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 308. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back, Lumbar supports.

Decision rationale: The request for the Kronos lumbar support is not medically necessary. The American College of Occupational and Environmental Medicine guidelines state that lumbar supports are not recommended for the treatment of low back disorders, they have not been shown to have last benefit beyond the acute phase of symptom relief. The injured worker is no longer in the acute phase of their injury. There is no indication that the injured worker has any significant pathology for which a lumbar support would be indicated. There is no evidence of instability. The requesting physician's rationale for the request is not indicated within the provided documentation. Therefore, the Kronos lumbar support is not medically necessary.

Fluriflex Cream 240mg: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines.

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

Decision rationale: The request for the Fluriflex cream 240 mg is not medically necessary. The California MTUS Guidelines do not recommend any compounded product that contains at least 1 drug or drug class that is not recommended. The California MTUS Guidelines recommend non-steroidal anti-inflammatory agents for the treatment of osteoarthritis, and tendonitis, particularly that of the knee and elbow for short-term use of 4 to 12 weeks. There is little evidence for topical NSAID treatment of osteoarthritis in the spine, hip, or the shoulder. The guidelines note there is no evidence for the use of any muscle relaxant for topical application. The injured worker complains of back pain and foot pain. It is unknown how long the injured worker has been using this medication. There is no evidence that the injured worker has a diagnosis of osteoarthritis and tendinitis, in particular, to a joint that is amenable to topical treatment. The guidelines do not recommend muscle relaxants for topical application. As the guidelines note any compounded product that contains at least 1 drug or drug class that is not recommended, the medication would not be indicated. Therefore, the Fluriflex cream 240 mg is not medically necessary.

TGHOT Cream 240gm: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines.

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

Decision rationale: The TGHot cream 240 gm. is not medically necessary. TG Hot is comprised of Capsaicin, Tramadol and Gabapentin. The California MTUS Guidelines do not recommend any compounded product that contains 1 drug or drug class that is not recommended. Capsaicin is recommended as an option in patients who have not responded or are intolerant to other treatments. There was a lack of documentation provided that other treatments were used and not tolerated. The guidelines note Gabapentin is not recommended as there is no peer-reviewed literature to support use. Peer-reviewed literature states that there is a deficiency of higher quality evidence in the role of topical opioids, and that more robust primary studies are required to inform practice recommendations. There is no indication that the injured worker has not responded to or is intolerant of other treatments. Per the guidelines and peer reviewed literature, Tramadol and Gabapentin and not recommended for topical application. As the guidelines note any compounded product that contains 1 drug or drug class that is not recommended, the medication would not be indicated. Additionally, the request does not indicate the frequency at which the medication is prescribed and the site at which it is to be applied in order to determine the necessity of the medication. Therefore, the TGHot cream is not medically necessary.