

Case Number:	CM14-0099079		
Date Assigned:	09/16/2014	Date of Injury:	08/24/2010
Decision Date:	10/15/2014	UR Denial Date:	06/04/2014
Priority:	Standard	Application Received:	06/27/2014

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 & Rehabilitation, has a subspecialty in Pain Management and is licensed to practice in Texas & Oklahoma. 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 59-year-old female with a reported injury on 08/24/2010. The mechanism of injury was not provided. The injured worker's diagnoses include left knee arthropathy, lumbosacral disc degeneration, and torn rotator cuff (side not specified). The injured worker's past treatments included medication, physical therapy, and activity limitation with walker, acupuncture, aquatic therapy, and cervical epidural steroid injections. The injured worker's diagnostic testing has included a lumbar spine MRI on 07/25/2014 and 11/18/2011, EMG/NCV on 12/14/2012 which was normal, a left knee MRI on 02/19/2012, a cervical spine MRI on 12/11/2013. The injured worker's surgical history included shoulder surgery on 04/20/2013 and 2 knee surgeries. The injured worker was evaluated on 08/26/2014 for neck pain rated in intensity of 4/10 to 6/10 with radiation to the right arm, low back pain rated 7/10 to 8/10 in intensity with radiation to the lower extremities, right shoulder pain rated 5/10 to 6/10 in intensity, and bilateral knee pain rated 7/10 to 8/10. The objective findings portion of the visit reads positive cervical MRI, positive lumbar spine MRI, positive right rotator MRI, negative carpal tunnel syndrome right wrist. The clinician also reported the cervical epidural steroid injection on 07/13/2014 helped. The treatment plan is to continue naproxen, Omeprazole, and Norco. The request was for Flurbiprofen 25% and tramadol 15% cream. No rationale for this request was provided. No request for authorization form was provided.

IMR ISSUES, DECISIONS AND RATIONALES

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

Flurbiprofen 25% and tramadol 15% cream: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines; Topical Application;Com.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113.. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: B LeBon, G Zeppetella, IJ Higginson (2009). Effectiveness of topical administration of opioids in palliative care: a systematic review. Journal of pain and symptoms-Elsevier.

Decision rationale: The request for Flurbiprofen 25% and Tramadol 15% cream is not medically necessary. The injured worker continued to complain of neck, low back, shoulder, and knee pain. The California MTUS Chronic Pain Guidelines state that Voltaren gel 1% is the only FDA approved topical non-steroidal anti-inflammatory drug for treatment of osteoarthritis pain in joints that lend themselves to topical treatment. Any compounded product that contains at least 1 drug (or drug class) that is not recommended is not recommended. Peer reviewed literature states that there is a deficiency of higher quality evidence on the role of topical opioids and that more robust primary studies are required to inform practice recommendations. The compound topical cream requested includes a non-steroidal anti-inflammatory that is not FDA approved for the topical treatment of osteoarthritis and an opioid that is not recommended by the California MTUS Chronic Pain Guidelines. Additionally, the request did not include a dosage amount or a site of application. Therefore, the request for Flurbiprofen 25% and Tramadol 15% cream is not medically necessary.