

MAXIMUS FEDERAL SERVICES, INC.

Independent Medical Review
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(855) 865-8873 Fax: (916) 605-4270



Notice of Independent Medical Review Determination

Dated: 12/6/2013

[REDACTED]

[REDACTED]

| | |
|---------------------------|--------------|
| Employee: | [REDACTED] |
| Claim Number: | [REDACTED] |
| Date of UR Decision: | 7/12/2013 |
| Date of Injury: | 7/25/2007 |
| IMR Application Received: | 8/16/2013 |
| MAXIMUS Case Number: | CM13-0007969 |

- 1) MAXIMUS Federal Services, Inc. has determined the request for **Tramadol ER 150mg #60 is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for **FluriFlex (Flurbiprofen/Cyclobenzaprine 15/10%) cream 180gm is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for **TGHot (Tramadol/Gabapentin/Menthol/Camphor/Capsaicin 8/10/2/.05%) cream 180gm is not medically necessary and appropriate.**

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 8/16/2013 disputing the Utilization Review Denial dated 7/12/2013. A Notice of Assignment and Request for Information was provided to the above parties on 9/6/2013. A decision has been made for each of the treatment and/or services that were in dispute:

- 1) MAXIMUS Federal Services, Inc. has determined the request for **Tramadol ER 150mg #60 is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for **FluriFlex (Flurbiprofen/Cyclobenzaprine 15/10%) cream 180gm is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for **TGHot (Tramadol/Gabapentin/Menthol/Camphor/Capsaicin 8/10/2/.05%) cream 180gm is not medically necessary and appropriate.**

Medical Qualifications of the Expert Reviewer:

The independent Medical Doctor who made the decision has no affiliation with the employer, employee, providers or the claims administrator. The physician 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 treatments and/or services at issue.

Expert Reviewer Case Summary:

The patient is a 64-year-old female who reported an injury on 04/13/2013. A clinical note signed by Dr. [REDACTED] dated 07/12/2013 reported the patient complained of aching pain in the cervical spine with pain radiating through the right shoulder with stiffness of the cervical region, which was aggravated by turning her head from side to side and tilting her head up and down. She had reported aching pain in the right shoulder with pain radiating to her forearm. She notes instability, locking, and popping of the right shoulder; and increased pain with lifting and carrying more than 15 pounds. She also reported aching pain in the low back, radiating to the lower extremities to the feet and weakness of the lower extremities. On physical examination of the right shoulder, the patient had anterior capsular tenderness, hypertrophic acromioclavicular joint, weakness of the shoulder musculature, and on internal and external rotation, abduction was to 120 degrees, flexion was to 120 degrees, and internal and external rotation were significantly impaired. The patient is noted to have a positive sciatic stretch sign of the lumbar spine. An MRI of the right shoulder reported to have been performed on 06/14/2010 was reported to show significantly increased signal in the area of the subacromial bursa, and a significant likelihood of a rotator cuff tear with subacromial joint arthrosis as well. The clinical note dated 08/02/2013 reported the patient complained of right shoulder and back pain, and had slight increase and swelling of the right ankle. She is reported to use medications periodically. On examination of the right shoulder, she had a weakness, crepitus, a mildly positive drop arm test, and abduction

limited to 120 degrees. Examination of the lumbar spine noted tenderness in the paralumbar musculature with limited range of motion, forward flexion to 10 degrees, and extension to 10 degrees, tilt to right and left was 15 degrees, and neurovascular status was unchanged.

Documents Reviewed for Determination:

The following relevant documents received from the interested parties and the documents provided with the application were reviewed and considered. These documents included:

- Application of Independent Medical Review
- Utilization Review Determination
- Medical Records from Claims Administrator
- Medical Treatment Utilization Schedule (MTUS)

1) Regarding the request for Tramadol ER 150mg #60:

Section of the Medical Treatment Utilization Schedule Relied Upon by the Expert Reviewer to Make His/Her Decision

The Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines, which is a part of the MTUS.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Opioids, Criteria for Use, pg. 78, which is part of the MTUS.

Rationale for the Decision:

MTUS Chronic Pain Medical Treatment Guidelines indicate that it is recommended that there is documentation of ongoing pain relief received by the use of narcotic analgesics, along with functional status, appropriate medication use and side effects. The pain assessment should include current pain, least reported pain over the period since last assessment, average pain, intensity of pain after taking the opioid, and how long it takes for pain relief, and how long the pain relief lasts. Satisfactory responses to treatment may be indicated by the employee's decreased pain, increased level of function, or improved quality of life. The medical records provided for review indicate there is no documentation that the employee receives pain relief with the use of Tramadol or that the employee has improved functional status, or that the employee has been assessed for appropriate medication use or possible side effects or possible aberrant or non-adherent drug-related behaviors. **The request for tramadol ER 150 mg #60 is not medically necessary and appropriate.**

2) Regarding the request for FluriFlex (Flurbiprofen/Cyclobenzaprine 15/10%) cream 180gm:

Section of the Medical Treatment Utilization Schedule Relied Upon by the Expert Reviewer to Make His/Her Decision

The Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines, which is a part of the MTUS.

The Expert Reviewer based his/her decision on the MTUS Chronic Pain Medical Treatment Guidelines, Topical Analgesics, pgs 111-113, which is part of the MTUS.

Rationale for the Decision:

The medical records provided for review indicate that the employee is reported to complain of ongoing pain of the cervical spine, right shoulder, and low back. MTUS Chronic Pain Medical Treatment Guidelines state that there is little to no evidence to support the use of many topical analgesic compounded ointments, and any compounded product that contains at least one drug or drug class that is not recommended is not recommended. Guidelines state that topical nonsteroidal analgesics such as flurbiprofen are recommended for the use of osteoarthritis. However, Guidelines indicate they are recommended for certain use and only for joints that are amiable to topical treatment. Additionally, Guidelines indicate there is little evidence for treatment of topical non-steroidal anti-inflammatory drugs (NSAIDs) for osteoarthritis of the spine, hip, or shoulder. Guidelines do not recommend the use of muscle relaxants topically, as there is little evidence for the use of any muscle relaxants as a topical product. As the FluriFlex contains flurbiprofen and cyclobenzaprine, the requested compounded medication does not meet guideline recommendations. **The request for FluriFlex (Flurbiprofen /cyclobenzaprine 15/10%) cream 180 grams is not medically necessary and appropriate.**

3) Regarding the request for TGHOT (Tramadol/Gabapentin/Menthol/Camphor/Capsaicin 8/10/2/.05%) cream 180gm:

Section of the Medical Treatment Utilization Schedule Relied Upon by the Expert Reviewer to Make His/Her Decision

The Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines, which is a part of the MTUS.

The Expert Reviewer based his/her decision on the MTUS Chronic Pain Medical Treatment Guidelines, Topical Analgesics, pgs 111-113, which is part of the MTUS.

Rationale for the Decision:

The medical records provided for review indicate the employee was noted to have been prescribed TGHOT cream for injury to the right shoulder and low back. MTUS Chronic Pain Medical Treatment Guidelines state there is little or no documentation to support the use of many topical analgesics. Any compounded ointment that contains a drug or drug class that is not recommended is not

recommended. MTUS Chronic Pain Medical Treatment Guidelines state that Gabapentin is not recommended, as there is no peer reviewed literature to support the use. Capsaicin is recommended only as an option for patients who have not responded or who are intolerant to treatment and they recommend only the use of 0.025% formulation as a treatment for arthritis and 0.075% formulation for treatment of postherpetic neuralgia, diabetic neuropathy, and post-mastectomy pain. As the requested treatment contains Gabapentin, which is not recommended for use, and capsaicin in a 0.5% formulation, the requested TGHot cream does not meet Guideline recommendations. **The request for TGHot (Tramadol/Gabapentin/Menthol/Camphor/Capsaicin 8/10/2/0.5%) cream 180 grams is not medically necessary and appropriate.**

Effect of the Decision:

The determination of MAXIMUS Federal Services and its physician reviewer is deemed to be the final determination of the Administrative Director, Division of Workers' Compensation. With respect to the medical necessity of the treatment in dispute, this determination is binding on all parties.

In accordance with California Labor Code Section 4610.6(h), a determination of the administrative director may be reviewed only if a verified appeal is filed with the appeals board for hearing and served on all interested parties within 30 days of the date of mailing of the determination to the employee or the employer. The determination of the administrative director shall be presumed to be correct and shall be set aside only upon proof by clear and convincing evidence of one or more of the grounds for appeal listed in Labor Code Section 4610.6(h)(1) through (5).

Sincerely,

Paul Manchester, MD, MPH
Medical Director

cc: Department of Industrial Relations
Division of Workers' Compensation
1515 Clay Street, 18th Floor
Oakland, CA 94612

/ejf

Disclaimer: MAXIMUS is providing an independent review service under contract with the California Department of Industrial Relations. MAXIMUS is not engaged in the practice of law or medicine. Decisions about the use or nonuse of health care services and treatments are the sole responsibility of the patient and the patient's physician. MAXIMUS is not liable for any consequences arising from these decisions.