

Case Number:	CM13-0036209		
Date Assigned:	12/13/2013	Date of Injury:	05/25/2006
Decision Date:	02/25/2014	UR Denial Date:	09/26/2013
Priority:	Standard	Application Received:	10/18/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she 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 Illinois. 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 physician 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 patient is a 70-year-old male who reported an injury on 05/25/2006. The mechanism of injury was not provided. The patient had a history significant for cervical spinal fusion. The patient developed chronic pain in the low back and bilateral knees. The patient underwent total left knee replacement in 05/2013. The patient's postsurgical pain was managed with physical therapy and medications. Prior treatments for the patient's back pain included chiropractic care, medications, physical therapy, and epidural steroid injections. The patient's most recent physical evaluation of the left knee revealed range of motion described as full extension to 110 degrees in flexion, with no notable instability and quad strength rated at a 4/5. The most recent evaluation of the patient's lumbosacral spine included tenderness to palpation of the cervical and lumbar paraspinal musculature. The patient's diagnoses included post left total knee replacement arthroplasty, lumbosacral hernia, and cervical spine history of fusion. The patient's treatment plan included physical therapy and medication usage.

IMR ISSUES, DECISIONS AND RATIONALES

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

Flurbi (NAP) cream 180 grams (flurbiprofen 20% lidocaine 5% Amitriptyline 5%): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111. Decision based on Non-MTUS Citation Antidepressants for the new millennium (1999), Eur J Pharmacol 375:31-40, P. Skolnick.

Decision rationale: The requested flurbi cream 180 grams is not medically necessary or appropriate. The requested compound contains flurbiprofen, lidocaine, and amitriptyline. The California Medical Treatment Utilization Schedule recommends the use of topical nonsteroidal anti-inflammatory drugs when patients are intolerant of oral formulations. The clinical documentation submitted for review does not provide any evidence that the patient is intolerant of oral formulations of nonsteroidal anti-inflammatory drugs. The California Medical Treatment Utilization Schedule does not recommend the use of lidocaine in a cream formulation, as it is not FDA-approved for the treatment of neuropathic pain. Peer-reviewed literature does not recommend the use of amitriptyline as a topical agent, as there is no scientific evidence to support the efficacy of antidepressants in topical agents. The California Medical Treatment Utilization Schedule states that any compounded medication that contains at least 1 drug or drug class that is not supported by guideline recommendations is not recommended. As such, the requested flurbi (NAP) cream 180 grams (flurbiprofen 20% lidocaine 5% amitriptyline 5%) is not medically necessary or appropriate.

Gabacyclotram 180 grams (gabapentin 10% cyclobenzaprine 5% tramadol): Upheld

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

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

Decision rationale: The requested gabacyclotram 180 grams (gabapentin 10%, cyclobenzaprine 5%, tramadol) is not medically necessary or appropriate. The clinical documentation submitted for review does provide evidence that the patient has ongoing pain complaints that would benefit from medication usage. The guidelines do not recommend the use of gabapentin as a topical agent due to lack of scientific evidence to support the efficacy of this medication. Additionally, the California Medical Treatment Utilization Schedule does not recommend the use of cyclobenzaprine as a topical agent due to lack of scientific evidence to support the efficacy of this type of medication. Also, peer-reviewed literature does not recommend opioids such as tramadol in topical formulations due to lack of scientific evidence to support the efficacy of this type of medication. The California Medical Treatment Utilization Schedule states that any compounded medication that contains at least 1 drug or drug class that is not supported by guideline recommendations is not recommended. As such, the requested gabacyclotram 180 grams (gabapentin 10%, cyclobenzaprine 5%, tramadol) is not medically necessary or appropriate.

Physical therapy (3 times per week for 4 weeks): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 98-99. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Knee & Leg, Physical Medicine Treatment.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99.

Decision rationale: The requested physical therapy is not medically necessary or appropriate. The clinical documentation submitted for review does provide evidence that the patient has had significant physical therapy during the course of the injury. The California Medical Treatment Utilization Schedule recommends that patients be transitioned into a home exercise program to maintain improvements obtained during skilled physical therapy. Clinical documentation submitted for review does provide evidence that the patient is participating in a home exercise program for the knee. However, there is no documentation of a home exercise program focused on the low back or cervical spine. Therefore, a short course of physical therapy would be indicated to re-established and re-educate the patient in a focused home exercise program. However, the requested 3 times a week for 4 weeks would be considered excessive. As such, the requested physical therapy 3 times per week for 4 weeks is not medically necessary or appropriate.

Prilosec 20mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 98-99.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk Page(s): 68.

Decision rationale: The requested Prilosec is not medically necessary or appropriate. The clinical documentation submitted for review does provide evidence that the patient has been on nonsteroidal anti-inflammatory drugs for an extended duration. The California Medical Treatment Utilization Schedule recommends gastrointestinal protectants for patients who are at risk for developing gastrointestinal disturbances related to medication usage. The clinical documentation submitted for review did not include an assessment of the patient's gastrointestinal system to support the need for a gastrointestinal protectant. There was no evidence provided that the patient has any gastrointestinal upset related to medication usage. As such, the requested Prilosec 20 mg #60 is not medically necessary or appropriate.