

Case Number:	CM13-0038908		
Date Assigned:	12/18/2013	Date of Injury:	01/03/2002
Decision Date:	02/11/2014	UR Denial Date:	09/30/2013
Priority:	Standard	Application Received:	10/02/2013

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, has a subspecialty in Neuromuscular Medicine and is licensed to practice in Maryland. 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. 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:

Patient is a 60-year-old female secretary who sustained injury on 1/3/02 when she twisted her left knee while chasing a burglary suspect. Per documentation patient was seen and diagnosed with a left torn medial meniscus tear, chronic right ankle sprain, and old un-united fracture of the medial malleolus, dorsolumbosacral strain and mild degenerative changes in the talus. She also injured her low back. She is currently diagnosed with lumbar musculoligamentous sprain/strain with left lower extremity radiculopathy, left knee Osteoarthritis and right foot small digit fracture. A request was made for a tube of Flurbiprofen 20% gel and a one-month supply of Medrox patches. She had had left knee surgery in 1983 and a right Achilles surgery in the 1980s. She has also undergone Supartz injections and another two left knee surgeries in 2003 and 2008. Other treatments she received have included PT, chiropractic treatment, and a walking boot. As per documentation, at the 10/25/13 visit note, the patient complained of low back pain, 4/10 on VAS. She also complained of left knee pain, 7/10 on VAS; and bilateral ankle/foot pain, 4/10 on VAS. The request is whether Medrox patches (1 month supply) and Flurbiprofen 20% gel (to be applied to the affected area 2-3 times a day) is medically necessary.

IMR ISSUES, DECISIONS AND RATIONALES

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

Flurbiprofen 20% gel: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 110-111.

Decision rationale: Flurbiprofen 20% gel (to be applied to the affected area 2-3 times a day) is not medically necessary per MTUS guidelines. Per MTUS guidelines: Topical Non-steroidal ant inflammatory agents (NSAIDs): "The efficacy in clinical trials for this treatment modality has been inconsistent and most studies are small and of short duration. Topical NSAIDs have been shown in meta-analysis to be superior to placebo during the first 2 weeks of treatment for osteoarthritis, but either not afterward, or with a diminishing effect over another 2-week period. Indications: Osteoarthritis and tendinitis, in particular, that of the knee and elbow or other joints that are amenable to topical treatment: Recommended for short-term use (4-12 weeks). There is little evidence to utilize topical NSAIDs for treatment of osteoarthritis of the spine, hip or shoulder." From submitted documentation it is not clear to what body part patient will be applying Flurbiprofen. Flurbiprofen is not indicated for osteoarthritis of the spine. Chronic Pain Medical Treatment Guidelines 8 C.C.R. Â§Â§9792.20 - 9792.26 MTUS (Effective July 18, 2009) Page 110-111 of 127 Topical Analgesics Recommended as an option as indicated below. Largely experimental in use with few randomized controlled trials to determine efficacy or safety. Primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. (Namaka, 2004) These agents are applied locally to painful areas with advantages that include lack of systemic side effects, absence of drug interactions, and no need to titrate. (Colombo, 2006) Many agents are compounded as monotherapy or in combination for pain control (including NSAIDs, opioids, capsaicin, local anesthetics, antidepressants, glutamate receptor antagonists, $\hat{1}\pm$ -adrenergic receptor agonist, adenosine, cannabinoids, cholinergic receptor agonists, $\hat{1}^3$ agonists, prostanoids, bradykinin, adenosine triphosphate, biogenic amines, and nerve growth factor). (Argoff, 2006) There is little to no research to support the use of many of these agents. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. The use of these compounded agents requires knowledge of the specific analgesic effect of each agent and how it will be useful for the specific therapeutic goal required. [Note: Topical analgesics work locally underneath the skin where they are applied. These do not include transdermal analgesics that are systemic agents entering the body through a transdermal means. See Duragesic^Â (fentanyl transdermal system).] Non-steroidal ant inflammatory agents (NSAIDs): The efficacy in clinical trials for this treatment modality has been inconsistent and most studies are small and of short duration. Topical NSAIDs have been shown in meta-analysis to be superior to placebo during the first 2 weeks of treatment for osteoarthritis, but either not afterward, or with a diminishing effect over another 2-week

1 month supply of Medrox Patches: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 28,105.

Decision rationale: 1 month supply of Medrox Patches is not medically necessary per MTUS guidelines. A Medrox patch consists of Menthol, Capsaicin, and Methyl Salicylate. Medrox Patch consists of Methyl Salicylate 5%; Menthol 5%; Capsaicin 0.0375%. Per MTUS guidelines there are no studies of a 0.0375% formulation of capsaicin and this exceeds guideline recommendations, therefore the Medrox patch is not medically necessary. Per guidelines Salicylate topicals including methyl salicylate and menthol are recommended however the patch formulation of both of these formulations in combination with Capsaicin is not specifically mentioned in the MTUS.