

Case Number:	CM13-0062630		
Date Assigned:	12/30/2013	Date of Injury:	09/24/2007
Decision Date:	03/31/2014	UR Denial Date:	11/27/2013
Priority:	Standard	Application Received:	12/06/2013

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 Internal Medicine has a subspecialty in Pulmonary Diseases 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 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 sustained an injury on 09/24/2007 of unspecified nature. The patient was noted to have a history of arthroplasty to the left knee. The patient was evaluated on 09/19/2013 for continued experience of left knee pain. The examination indicated the patient was treating his pain with pain medication. The objective findings of the examination indicated the patient had a well healed incision that was hypersensitive. Documentation further notes the patient had good extension and 4+/5 strength at 0 degrees. There was no noted instability; however, the patient did have noted atrophy of the left thigh relative to the right of 3 cm. The patient was noted to have pain to palpation at the anteromedial joint line. The documentation submitted for review dated 09/19/2013 did not have a treatment plan included.

IMR ISSUES, DECISIONS AND RATIONALES

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

The request for Flurbiprofen 10%/Cyclobenzaprine 1%/Gabapentin 6%/Lidocaine 2%/Prilocaine 2% DUR compound with 5 refills: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesic Page(s): 111-112.

Decision rationale: The request for Flurbiprofen 10%/Cyclobenzaprine 1%/Gabapentin 6%/Lidocaine 2%/Prilocaine 2% DUR compound with 5 refills is non-certified. The California MTUS Guidelines state any compound product that contains at least 1 drug (or drug class) that is not recommended, is not recommended. The request specifies Flurbiprofen which is classified as a nonsteroidal anti-inflammatory agent. This agent is not currently FDA approved for topical application. As the topical Flurbiprofen is not supported by the FDA, it is not supported by the treatment guidelines. In addressing the Cyclobenzaprine, there is no evidence for use of any muscle relaxant as a topical product. Therefore, the use of the Cyclobenzaprine is not supported. The guidelines further state Gabapentin is not recommended as a topical analgesic. The guidelines state the use of Lidocaine is recommended as a topical analgesic for patients with neuropathic pain. The documentation submitted for review did not indicate the patient had neuropathic pain. The patient's diagnosis was noted as left medial compartmental pain. Thus, the use of the Lidocaine is not supported. As none of the ingredients to the compounded topical analgesic are supported, its use is not supported. Given the information submitted for review, the request for Flurbiprofen 10%/Cyclobenzaprine 1%/Gabapentin 6%/Lidocaine 2%/Prilocaine 2% DUR compound with 5 refills is non-certified.