

<b>Case Number:</b>	CM14-0100648		
<b>Date Assigned:</b>	07/30/2014	<b>Date of Injury:</b>	05/03/2013
<b>Decision Date:</b>	09/09/2014	<b>UR Denial Date:</b>	06/03/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/30/2014

### 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 and Rehabilitation and is licensed to practice in Texas and Ohio. 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 30-year-old male who reported an injury on 05/03/2013. The mechanism of injury was noted to be slipping off a lawn mower. His diagnoses were noted to be synovitis, right knee, with effusion, and aggravated Osgood-Schlatter disease, right knee. Prior treatments were noted to be acupuncture and medications. Diagnostic studies were noted to be magnetic resonance imaging (MRI) and x-rays. It was noted in the clinical evaluation that the injured worker had no prior surgeries. The subjective complaints were noted in a clinical evaluation on 04/30/2014. The injured worker complained of moderate to severe pain in the right knee. He complained of radiating pain and swelling. He stated numbness with radiation into the right calf and right thigh. The objective physical exam findings were noted to be tenderness over the anteromedial and anterolateral joint lines, as well as significant tenderness over his tibial tubercle. There was no ligamentous instability. There was mild effusion. There was pain at the extremes of range of motion. It is noted the injured worker uses topical creams for pain relief. The treatment plan is for an MRI of the right knee. The provider's rationale for the request was not noted within the documentation. A Request for Authorization form was submitted with this review and dated 05/29/2014.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**FCMC Cream 120mg:** 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 Analgesics Page(s): 111-112.

**Decision rationale:** The California Medical Treatment Utilization Schedule (MTUS) Chronic Pain Medical Treatment Guidelines state topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. These are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Any compounded product that contains at least 1 drug (or drug class) that is not recommended is not recommended. Use of these compounded agents requires knowledge of the specific analgesic effect of each agent and how it will be useful in the specific therapeutic goal required. The medication FCMC is not indicated by the guidelines. It is unknown what combination it actually is and the percentages of each component. The documentation fails to document a failed trial of antidepressants or anticonvulsants. The provider's request does not indicate a frequency or application site. Therefore, the request for FCMC cream 120 mg is not medically necessary and appropriate.

**Keto cream 120:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines: Non FDA-approved agents.

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

**Decision rationale:** The California Medical Treatment Utilization Schedule (MTUS) Chronic Pain Medical Treatment Guidelines state topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. These are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Any compounded product that contains at least 1 drug (or drug class) that is not recommended is not recommended. Use of these compounded agents requires knowledge of the specific analgesic effect of each agent and how it will be useful in the specific therapeutic goal required. The specific components of Keto cream were not noted within the documentation provided for review. It is not clear what percent of each component is within the cream. It is also unclear what the frequency, dose, and application site is. Therefore, the request for Keto cream 120 is not medically necessary and appropriate.