

Case Number:	CM14-0011226		
Date Assigned:	02/21/2014	Date of Injury:	04/22/2011
Decision Date:	06/26/2014	UR Denial Date:	12/24/2013
Priority:	Standard	Application Received:	01/28/2014

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 & 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 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 38-year-old male who reported an injury, 04/22/2011. The mechanism of injury was not provided within the medical records. The clinical note dated 12/30/2013 indicated diagnoses of status post knee scope and lateral release on 09/15/2012, possible left knee internal derangement and status post right knee surgery 03/16/2013. The injured worker reported ongoing right knee pain that had increased with occasional swelling. He received an intra-articular joint injection with mild benefit. He reported he had a hard time performing activities of daily living due to his increased pain. On physical exam of the right knee, there was tenderness to the medial joint line. The range of motion was flexion at 120 degrees, extension at 0 degrees. The injured worker's McMurray's sign was positive. There was a positive patellar grinding, popping and clicking. The treatment plan included acupuncture 8 visits for the right knee. A Request for Authorization was submitted on 10/17/2013 for Fluriflex cream #180 gm to be applied to the affected area twice daily and for TG ice cream #180 to be applied to the affected area and right knee Solar Care Brace. However, a rationale was not provided for the TG ice cream and the Solar Care Brace.

IMR ISSUES, DECISIONS AND RATIONALES

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

FLURIFLEX CREAM 180 GM: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: CHRONIC PAIN MEDICAL TREATMENT GUIDELINES, ,

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113.

Decision rationale: Fluriflex contains (Flurbiprofen/Cylbenzaprine 15/10%). The California MTUS guidelines state that transdermal compounds are largely experimental in use with few randomized controlled trials to determine efficiency or safety. It is primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. 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. The guidelines note topical NSAIDs are recommended for osteoarthritis and tendinitis, in particular, that of the knee and elbow or other joints that are amenable to topical treatment 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. The guidelines state there is no evidence for use of any other muscle relaxant as a topical product. There was lack of evidence indicating osteoarthritis or tendinitis of the knee in the documentation. As Cyclobenzaprine is not recommended for topical application and the guidelines note any compounded medication containing at least one drug or drug class that is not recommended is not recommended, the medication would not be indicated. In addition the request did not provide a frequency for the medication. Therefore, per the California MTUS guidelines, the request for Fluriflex cream 180 gm is not medically necessary and appropriate.

TGICE 180 GM: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: CHRONIC PAIN MEDICAL TREATMENT GUIDELINES, ,

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

Decision rationale: TGICE contains (Tramadol/Gabapentin/Menthol/Camphor 8/10/2/2%). The California MTUS guidelines state that transdermal compounds are largely experimental in use with few randomized controlled trials to determine efficiency or safety. It is primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Many agents are compounded as monotherapy or in combination for pain control, including NSAIDs, opioids, capsaicin, local anesthetics, antidepressants, glutamate receptor antagonists, α-adrenergic receptor agonist, adenosine, cannabinoids, cholinergic receptor agonists, γ agonists, prostanoids, bradykinin, adenosine triphosphate, biogenic amines, and nerve growth factor. 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. The guidelines state that any compound that contains at least one drug is (or drug class) that is not recommended is not recommended. As Gabapentin is not recommended for topical application and the guidelines note any compounded medication containing at least one drug or drug class that is not recommended is not recommended, the medication would not be indicated. In addition, the request does not provide a frequency for the medication. Therefore, the request for TGICE 180 gm is not medically necessary and appropriate.

SOLAR CARE BRACE: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: CHRONIC PAIN MEDICAL TREATMENT GUIDELINES, ,

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 339-340.

Decision rationale: The CA MTUS/ACOEM guidelines state a brace can be used for patellar instability, anterior cruciate ligament (ACL) tear, or medial collateral ligament (MCL) instability although its benefits may be more emotional than medical. The guidelines also state a brace is necessary only if the patient is going to be stressing the knee under load, such as climbing ladders or carrying boxes. For the average patient, using a brace is usually unnecessary. In all cases, braces need to be properly fitted and combined with a rehabilitation program. There was a lack of evidence in the documentation to indicate the injured worker has any significant patellar instability, an anterior cruciate ligament (ACL) tear, or medial collateral ligament (MCL) instability. In addition, there was lack of documentation of the injured worker participating in a physical therapy or rehabilitation program. Therefore, per the CA MTUS/ACOEM guidelines, the request for Solar Care Brace is not medically necessary and appropriate.