

Case Number:	CM14-0015007		
Date Assigned:	03/21/2014	Date of Injury:	11/24/2009
Decision Date:	07/07/2014	UR Denial Date:	01/09/2014
Priority:	Standard	Application Received:	02/06/2014

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 Orthopedic Surgery, 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 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 54-year-old female who reported an injury on 11/24/2009 due to a fall. An MRI of the left knee dated 10/15/2013 revealed intrasubstance degenerative change within the posterior horn of the medial meniscus, meniscal tear or displaced meniscal fragment, intact ligaments and tendons, and mild chondromalacia of the articular cartilage of the median patellar ridge and lateral patellar facet. An MRI of the right knee performed 10/15/2013 revealed an oblique horizontal signal intensity within the posterior horn of the medial meniscus that closely approximates the inferior articular surface; the findings suggested an evolving tear. The clinical note dated 11/05/2013 noted that the injured worker presented with frequent headaches, constant low back pain radiating to the bilateral hips, bilateral knee pain, and sleep apnea. Prior treatments included Medrox, Ibuprofen and Soma. Upon examination, there were spasms throughout the back, tenderness over the sciatic notch, a small effusion noted in the bilateral knees, tenderness to palpation over the patellofemoral grind and lateral joint line as well as soft tissue swelling, and a small popliteal cyst. The diagnoses included status post transforaminal lumbar interbody fusion at L4-5 on 04/24/2013; status post anterior and posterior lumbar fusion at L5-S1; bilateral knee musculoligamentous sprain/strain, rule out internal derangement; and status post arthroscopy of the left knee. The current treatment plan included continued aquatic therapy for the lumbar spine 2 to 3 times a week as well as the continuation of Prilosec, Medrox patches, flurbiprofen ketoprofen/ketamine gel, and gabapentin/cyclobenzaprine/capsaicin cream, in addition to a request for a Synvisc injection bilaterally with 3 injections to each knee to enhance cartilage repair. The provider's rationale for the topical creams was to provide an adjunctive treatment to allow a reduction in the total amount of oral medications required, minimizing the potential side effects of oral medications. The Request for Authorization form was submitted 11/05/2013.

IMR ISSUES, DECISIONS AND RATIONALES

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

SYNVISC INJECTIONS TO BILATERAL KNEES: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee, Hyaluronic acid injections.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 337.

Decision rationale: The request for a Synvisc injection to the bilateral knees is non-certified. ACOEM/California MTUS state that invasive techniques, such as needle aspiration effusions or prepatellar bursal fluid and cortisone injections, are not routinely indicated. The aspirations carry an inherent risk of subsequent intra-articular infection. Nonprescription analgesics will provide sufficient pain relief for most injured workers with acute and subacute symptoms. If the treatment response is inadequate, prescribed pharmaceuticals or physical methods can be added. Comorbid conditions, side effects, costs, and provider and injured worker preferences guide the clinician's choice of recommendations. The included documentation states that the injured worker has been consistent with aquatic therapy for the lumbar spine, but there is no mention as to whether the injured worker has had physical therapy specifically for the knees. The documentation notes tenderness, swelling and a small effusion noted in the bilateral knees; however, there is a lack of significant objective exam findings to support possible pathology to warrant a Synvisc injection to the bilateral knees. As such, the request is non-certified.

PRILOSEC 20MG #30: 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 GI symptoms & Cardiovascular Risk Page(s): 68.

Decision rationale: The request for Prilosec 20 mg with a quantity of 30 is non-certified. The California MTUS Guidelines recommend proton pump inhibitors for injured workers at risk for gastrointestinal events. The guidelines recommend that clinicians use the following criteria to determine if the injured worker is at risk for gastrointestinal events, to include: age greater than 65 years old; history of peptic ulcer, GI bleeding or perforation; concurrent use of ASA, corticosteroids and/or an anticoagulant; or high dose/multiple NSAID use. The medical documents do not indicate that the injured worker had gastrointestinal symptoms. It is unclear if the injured worker has a history of peptic ulcer, GI bleed or perforation. It did not appear that the injured worker was at risk for gastrointestinal events. Therefore, the request is non-certified.

FLURBIPROFEN 20% GEL 120 GM: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TOPICAL ANALGESICS Page(s): 111-112.

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

Decision rationale: The request for flurbiprofen 20% gel with a quantity of 120 gm is non-certified. The California MTUS Guidelines state that topical analgesics are largely experimental in use with few randomized, controlled trials to determine efficacy or safety. Topical analgesia is primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Topical NSAIDs are recommended for osteoarthritis and tendonitis, in particular, that of the knee and elbow or other joints that are amenable to topical treatment. They are recommended for short-term use for 4 to 12 weeks. There is little evidence to utilize topical NSAIDs for the treatment of osteoarthritis of the spine, hip or shoulder. The medical documents did not specify that the injured worker has a diagnosis that would be consistent with the guideline recommendations for topical NSAIDs. There is a lack of documentation regarding the efficacy of the medication for the injured worker. The request did not indicate the frequency or the site for which the flurbiprofen gel was to be indicated for. As such, the request is non-certified.

KETOPROFEN 20% + KETAMINE 10% GEL 120 GM: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TOPICAL ANALGESICS Page(s): 111-112.

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

Decision rationale: The request for ketoprofen 20% plus ketamine 10% gel at 120 gm is non-certified. The California MTUS Guidelines state that topical analgesics are largely experimental in use with few randomized, controlled trials to determine efficacy or safety. Topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Any compounded product that contains at least 1 drug that is not recommended is not recommended. The guidelines note that ketoprofen is not currently FDA-approved for topical applications. The guidelines also state, ketamine is only recommended for treatment of neuropathic pain in refractory cases in which all primary and secondary treatment has been exhausted. The requested cream contains at least one drug that is not recommended; therefore, its use is not supported by guidelines. In addition, the request did not specify the frequency or the site at which the ketoprofen/ketamine gel was indicated for. As such, the request is non-certified.

GABAPENTIN 10% + CYCLOBENZAPRINE 10% WITH 0.375% CAPSAICIN 120 GM: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TOPICAL ANALGESICS Page(s): 111-112.

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

Decision rationale: The request for gabapentin 10% plus cyclobenzaprine 10% with 0.375% capsaicin at 120 gm is non-certified. The California MTUS Guidelines state that topical analgesics are largely experimental in use with few randomized, controlled trials to determine efficacy or safety. Topical analgesia is primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Any compounded product that contains at least 1 drug that is not recommended is not recommended. The guidelines note that capsaicin is recommended only as an option for injured workers who have not responded to, or are intolerant to other treatments. There is no current indication that a capsaicin formulation greater than 0.025% provides any further efficacy. The guidelines note that muscle relaxants are not recommended for topical applications. The guidelines note that gabapentin is not recommended for topical application. The included medical documentation does not indicate that the injured worker has not responded to or is intolerant to other treatments. The request does not indicate a frequency or a site at which the gabapentin/cyclobenzaprine/capsaicin cream was indicated for. The requested cream contains at least one drug that is not recommended; therefore, its use is not supported by guidelines. As such, the request is non-certified.