

Case Number:	CM14-0133232		
Date Assigned:	08/22/2014	Date of Injury:	09/18/2001
Decision Date:	09/30/2014	UR Denial Date:	07/23/2014
Priority:	Standard	Application Received:	08/20/2014

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 Pain Medicine and is licensed to practice in Texas & 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 72-year-old male who reported an injury on 09/18/2001 due to pulling some boxes on a dolly that weighed a total of 250 to 300 pounds, the injured worker's right foot got stuck on a pallet behind him, which caused him to fall onto his low back on the top of a pallet. The dolly struck him in the chest. The right knee was extended back. Diagnoses were bilateral carpal tunnel syndrome, chronic knee sprain, complex tear, lateral meniscus, right MRI, degenerative joint disease, right knee, chondromalacia, lateral/medial condyles, right, status post partial lateral meniscectomy, right knee and status post debridement, medial/lateral femoral condyle, right knee, status post total knee replacement, right, sacroiliac joint pain, knee pain, left, osteochondroma, left knee, and degenerative joint disease, left knee. Past treatments were medications, physical therapy, and numerous injections to the right knee. Diagnostic studies were MRI of the right knee. Past surgeries were 2 right knee surgeries and a right hip surgery. Physical examination on 04/16/2014 revealed the injured worker is status post total right knee replacement on 02/03/2014. The injured worker stated that he felt better. The injured worker had complaints of left knee pain. The left knee pain was rated a 7/10. The injured worker rated his right knee pain at a 4/10 to 5/10. He reported feeling slight numbness and tingling in the right knee. There were complaints of cervical spine pain, bilateral hand pain, and lumbar spine pain. The injured worker did report sleep was compromised by pain and discomfort some days. Examination of the right knee for tenderness was normal, the left knee was positive for medial joint line pain, lateral joint line, and medial femoral condyle pain. Reflexes and motor function for upper and lower extremities were normal. Medications were not reported. Treatment plan was to take medications as directed, and physical therapy. The rationale and Request for Authorization were not submitted.

IMR ISSUES, DECISIONS AND RATIONALES

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

Orphenadrine/Caffeine 50/10mg cap #60: 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 Muscle Relaxants Page(s): 63.

Decision rationale: The decision for Orphenadrine/Caffeine 50/10mg cap #60 is not medically necessary. The California Medical Treatment Utilization Schedule states muscle relaxants for pain are recommended with caution as a second line option for short term treatment of acute exacerbations in injured workers with chronic low back pain. Muscle relaxants may be effective in reducing pain and muscle tension, and increasing mobility. However, in most low back pain cases, they show no benefit beyond NSAIDs and pain in overall improvement. Also, there is no additional benefit shown in combination with NSAIDs. Efficacy appears to diminish over time, and prolonged use of some medications in this class may lead to dependence. The efficacy of this medication was not reported. Also, the request does not indicate a frequency for the medication. Therefore, the request is not medically necessary.

Flurbirofen/cyclo/menth cream 20%/10%/4% #180gm: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Flurbiprofen, page 72, Topical Analgesics, page 111, Cyclobenzaprine, page 41 Page(s): 72, 111, 41.

Decision rationale: The decision for Flurbirofen/cyclo/menth cream 20%/10%/4% #180gm is not medically necessary. The California Medical Treatment Utilization Schedule Guidelines indicate that topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. They 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. 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. FDA approved routes of administration for Flurbiprofen include oral tablets and ophthalmologic solution. A search of the National Library of Medicine/National Institute of Health Database demonstrated no high quality human studies evaluating the safety and efficacy of this medication through dermal patches or topical administration. The guidelines do not recommend the topical use of cyclobenzaprine as a topical muscle relaxant as there is no evidence for use of any other muscle relaxant as a topical product. The addition of cyclobenzaprine to other agents is not recommended. The medical guidelines do not support the

use of compounded topical analgesics. The request does not indicate a frequency for the medication. Therefore, the request is not medically necessary.

Keratek gel #4 ounces: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics, page 111, Topical Salicylates, page 105 Page(s): 111, 105.

Decision rationale: The decision for Keratek gel #4 ounces is not medically necessary. The California Medical Guidelines indicate that topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. They 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. Topical salicylates are recommended for use. The efficacy of this medication was not reported. Also, the request does not indicate a frequency for the medication. Therefore, it is not medically necessary.

Hydrocodone/Apap/Onandan 10/300/2mg #40: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines CA MTUS; Opioids; Page(s): page 74.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Ongoing Management, page 78, Hydrocodone/Acetaminophen, page 91 Page(s): 78, 91.

Decision rationale: The decision for Hydrocodone/Apap/Onandan 10/300/2mg #40 is not medically necessary. The California Medical Treatment Utilization Schedule recommend that there should be documentation of the 4 A's for ongoing monitoring of opioid medication. This should include analgesia, activities of daily living, adverse side effects, and aberrant drug taking behavior. It further recommends that dosing of opioids not exceed 120 mg oral morphine equivalence per day. The efficacy of this medication was not reported. The request does not indicate a frequency for the medication. Therefore, the request is not medically necessary.

Gabapentin/Pyridoxine 250mg/10mg #60: 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 Specific Drug List, Gabapentin Page(s): 16.

Decision rationale: The decision for Gabapentin/Pyridoxine 250mg/10mg #60 is not medically necessary. The California Medical Treatment Utilization Schedule Guidelines indicate that

gabapentin is shown to be effective for treatment of diabetic painful neuropathy and postherpetic neuralgia and has been considered as a first line treatment for neuropathic pain. The efficacy of this medication was not reported. Also, the request does not indicate a frequency for the medication. Therefore, it is not medically necessary.

Omeprazole10/Flurbiprofen 100mg #60: 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 NSAIDs, page 67, Flurbiprofen, page 72 Page(s): 67, 72.

Decision rationale: The request for Omeprazole/Flurbiprofen 100mg #60 is not medically necessary. Clinicians should determine if the patient is at risk for gastrointestinal events which include age > 65 years, a history of peptic ulcer, GI bleeding or perforation, concurrent use of ASA, corticosteroids, and/or an anticoagulant; or using a high dose/multiple NSAIDs. Patients with no risk factor and no cardiovascular disease: Non-selective NSAIDs OK (e.g, ibuprofen, naproxen, etc.) Patients at intermediate risk for gastrointestinal events and no cardiovascular disease: (1) A non-selective NSAID with either a PPI (Proton Pump Inhibitor, for example, 20 mg omeprazole daily) or misoprostol (200 g four times daily) or (2) a Cox-2 selective agent. Long-term PPI use (> 1 year) has been shown to increase the risk of hip fracture. Patients at high risk for gastrointestinal events with no cardiovascular disease: A Cox-2 selective agent plus a PPI if absolutely necessary. Flurbiprofen is a non-steroidal anti-inflammatory agent. The efficacy of this medication was not reported. The request does not indicate a frequency for the medication. Therefore, the request is not medically necessary. Flurbiprofen is classified as a nonsteroidal anti-inflammatory agent. The efficacy of this medication was not reported. Also, the request does not indicate a frequency for the medication. Therefore, the request is not medically necessary.