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| Case Number: | CM14-0134808 | | |
| Date Assigned: | 08/27/2014 | Date of Injury: | 07/12/2011 |
| Decision Date: | 10/14/2014 | UR Denial Date: | 07/23/2014 |
| Priority: | Standard | Application Received: | 08/21/2014 |

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 Nevada. 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 63 year-old male who was reportedly injured on July 12, 2011. A February 27, 2014 progress note indicates a follow-up for coronary artery disease of hyperlipidemia. The most recent progress note dated July 9, 2014, indicates that there were ongoing complaints of knee pain. The physical examination demonstrated a limitation of flexion (40). No other findings were reported. Diagnostic imaging studies objectified a total knee arthroplasty in place and no objective data demonstrating loosening of the components. Previous treatment includes knee surgery (totally arthroplasty), postoperative physical therapy, multiple medications, and pain management interventions. A request was made for multiple medications and was not certified in the pre-authorization process on July 23, 2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Orphenadrine/Caffeine 50/10mg: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 65.

Decision rationale: Orphenadrine is used to treat painful muscle spasms and Parkinson's. The combination of anti-cholinergic effects and CNS penetration make it very useful for pain of all etiologies including radiculopathy, muscle pain, neuropathic pain, and various types of headaches. This medication has abuse potential due to a reported euphoric and mood elevating effect, and therefore should be used with caution as a 2nd line option for short-term use in both acute and chronic low back pain. Based on the clinical documentation provided, the clinician does not document trials of any previous anticonvulsant medications or medications for chronic pain such as Gabapentin. Furthermore, the efficacy and utility of this medication are not established the progress notes reviewed. Therefore, there is insufficient clinical information to support the medical necessity of this medication.

Gabapentin/Pyridoxine 250mg/10mg, #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 16-20, 49.

Decision rationale: This is a medication shown to be effective for painful diabetic neuropathy or post-herpetic neuralgia. It is also noted as a first-line treatment for neuropathic pain disorder. However, the lease identified indicates a nociceptive pain disorder. Furthermore, there is nothing in the progress notes suggesting any efficacy or utility with the utilization of medication. Therefore, based on the clinical information presented for review this is not medically necessary.

Keratek Gel, #4 oz.: Upheld

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

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

Decision rationale: As noted in the California Medical Treatment Utilization Schedule guidelines, such topical preparations are "largely experimental" and any compound product that has at least one drug that is not recommended, is not recommended. There is little data presented support the use of menthol the postoperative treatment of a total knee arthroplasty. Furthermore, there is no documentation of any other medications or that this preparation has any objectified efficacy or utility. Seeing none, the medical necessity for continued use cannot be established.

Hydrocodone/APAP/Ondan 10/300/2mg, #40: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 74-78, 88, 91.

Decision rationale: This is a medication is a short acting opioid indicated for management of controlling moderate to severe pain. Furthermore, the lowest possible dose that allows for an increase in functionality or decrease in pain symptomology should be employed. It is noted there is a marked limitation range of motion after the surgery. However, there is no data presented to suggest that this medication is demonstrating any efficacy or utility. Seeing none, the medical necessity for continued use cannot be established.

Flurbiprofen/Cyclo/Menth Cream 10%/10%/4%, #180gm: 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 Page(s): 111-112.

Decision rationale: According to the California Chronic Pain Medical Treatment Guidelines the only topical analgesic medications indicated for usage include anti-inflammatories, Lidocaine, and Capsaicin. There is no known efficacy of any other topical agents. Per the MTUS, when one component of a product is not necessary the entire product is not medically necessary. Considering this, the request for this combination topical product is not medically necessary.

Omeprazole 10mg/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 Page(s): 68.

Decision rationale: This is a proton pump inhibitor useful in the treatment of gastroesophageal reflux disease. This is also noted is a gastric protectorate for those using non-steroidal medications. However, it is not clear what, if any oral non-steroidal is being employed, if there are any specific complaints, or that this medication has any noted efficacy or utility. Seeing none the progress notes presented for review there is insufficient clinical data to support the medical necessity of this.