

Case Number:	CM14-0176191		
Date Assigned:	10/29/2014	Date of Injury:	04/16/2013
Decision Date:	12/18/2014	UR Denial Date:	09/29/2014
Priority:	Standard	Application Received:	10/23/2014

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 Emergency Medicine and is licensed to practice in Texas. 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 65-year-old male who reported an injury on 04/16/2013. The mechanism of injury was pulling. The injured worker's diagnoses included left knee complex medial and lateral meniscus tears, left knee anterior cruciate ligament full thickness tear with severe tricompartmental osteoarthritis and severe joint space narrowing. The injured worker's past treatments included physical therapy, injections, and medications. The injured worker's diagnostic testing included x-rays of the left knee and of the left tibia, which were noted to show no loosening of the TKA. The injured worker's surgical history included a right shoulder arthroscopy in 07/2012, and a left total knee arthroplasty on 03/21/2014. On 07/14/2014, the injured worker reported improvement to his left knee with range of motion as a result of therapy. He reported some postoperative knee pain. Upon physical examination, the injured worker was noted with improvement with range of motion. The injured worker's medications included hydrocodone/APAP 10/325 mg, orphenadrine citrate ER 100 mg, diclofenac sodium ER 100 mg, and pantoprazole sodium ER 20 mg. The request was for orphenadrine/caffeine and compound cream (flurbiprofen 20%, cyclobenzaprine 10%, and menthol 4% 180 gm). The rationale for the orphenadrine was to relieve spasms. The Request for Authorization form was signed and submitted on 07/14/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Orphenadrine/Caffeine (50mg/10mg, #60): Upheld

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

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

Decision rationale: The request for orphenadrine/caffeine (5mg/10mg, #60) is not medically necessary. According to the California MTUS Guidelines, orphenadrine is similar to diphenhydramine, but has greater anticholinergic effects. The mode of action is not clearly understood. Effects are thought to be secondary to analgesic and anticholinergic properties. The anticholinergic effects include drowsiness, urinary retention, and dry mouth. Side effects may limit use in the elderly, the injured worker is 65 years old. The rationale for orphenadrine was for muscle relaxer/to relieve spasms. Upon physical examination, the injured worker was not noted to have spasm. The documentation did not provide sufficient evidence of significant objective functional limitations. In the absence of documentation with evidence of significant objective functional limitations and documented evidence of spasm, the request is not supported. Additionally, as the request was written, there was no frequency provided. Therefore, the request is not medically necessary.

Compound Cream (Flurbiprofen 20%, Cyclobenzaprine 10% and Menthol 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 Topical analgesics; Cyclobenzaprine Page(s): 111-114; 41.

Decision rationale: The request for compound cream (flurbiprofen 20%, cyclobenzaprine 10% and menthol 4%, 180gm) is not medically necessary. According to the California MTUS Guidelines, topical analgesics are largely experiment in use with few randomized controlled trials to determine efficacy or safety. 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. 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 efficacy in clinical trials for topical NSAIDs has been inconsistent and most studies are small of short duration. 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. The guidelines state the addition of cyclobenzaprine to other agents is not recommended. The injured worker complained of limited range of motion and stiffness of his left knee. The documentation indicated that the injured worker had been using topical creams for pain relief since at least 02/2014. The efficacy of the medications was not included in the documentation. In the absence of documentation with sufficient evidence of significant objective functional deficits, a complete and thorough pain

assessment to include a current quantified pain, and as the guidelines state that any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended, the request is not supported. Additionally, as the request was written, there was no frequency provided. Therefore, the request is not medically necessary.

Keratek Gel (Methyl salicylate/Menthol, 4oz): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation National Institute of Health

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

Decision rationale: The request for Keratek Gel (methyl salicylate/menthol, 4 oz) is not medically necessary. The California MTUS Guidelines state that topical salicylate is significantly better than placebo in chronic pain. Additionally, the guidelines state that many agents are compounded as monotherapy or in combination for pain control. 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 documentation did not provide sufficient evidence to show the intended therapeutic effect of menthol and whether the injured worker had tried and failed methyl salicylate as monotherapy. In the absence of the documentation specifying why menthol is necessary in combination with methyl salicylate, the request is not supported. Additionally, as the request is written, there was no frequency provided. Therefore, the request is not medically necessary.