

Case Number:	CM14-0020536		
Date Assigned:	04/25/2014	Date of Injury:	02/16/2011
Decision Date:	07/07/2014	UR Denial Date:	01/31/2014
Priority:	Standard	Application Received:	02/18/2014

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 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 patient is a 36 year old male who was injured on 02/16/2011 when he fell from a cart at work. Prior treatment history has included aquatic physical therapy and 5 series of Hyalgen injections to the right knee; Hydrocodone/APAP 10/325, cyclobenzaprine 7.5 mg, Diclofenac sodium ER 100 mg, and Pantoprazole sodium ER 20 mg. The patient underwent an arthroscopy of the right knee on 07/09/2013. X-rays were taken of the right knee and right tibia which show no increase of osteoarthritis. PR2 dated 01/06/2014 indicates the patient has right knee pain and his status is unchanged. He has swelling which becomes worse after prolonged walking. He rates his pain as an 8/10. On exam, he also reports stiffness and anterior tenderness of the right knee with restricted range of motion. He is noted to ambulate with a limp. The patient is given a prescription for Dyotin SR 250 mg #60 nerve, pain, Theraflex cream 180 mg for pain and inflammation; Keratek gel 4 oz for pain and inflammation; and midazolam/melatonin 10 mg #30. PR2 dated 10/10/2013 reports the patient noted his pain level as a 7/10. He reports no change in symptomatology. His exam is unchanged from note dated 01/06/2014. There is a noted request for authorization of the following medications: Dyotin SR 250 mg #60 nerve, pain, Theraflex cream 180 mg and Bio-Therm for pain and inflammation. Prior UR dated 01/31/2014 states the request for keratek gel 4 oz and theraflex transdermal cream 20%- 10%- 4% #180gm is non-certified as there is no clear diagnosis documented to assure effectiveness of the treatment and there is no documented neuropathy.

IMR ISSUES, DECISIONS AND RATIONALES

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

THERAFLEX TRANSDERMAL CREAM 20%- 10%- 4% #180GM: Upheld

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

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

Decision rationale: Guidelines indicate that topical analgesics are largely experimental 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. Since the medical record does not document that this patient has neuropathic pain or trials of oral antidepressants and anticonvulsants have failed, the medical necessity of Theraflex Transdermal Cream is not established. The request is not medically necessary and appropriate.

KERATEK GEL 4OZ: Upheld

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

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

Decision rationale: Guidelines indicate that topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. This is primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Since the medical record does not document that this patient has neuropathic pain or trials of oral antidepressants and anticonvulsants have failed, the medical necessity of Keratek Gel 4oz is not established. The request is not medically necessary and appropriate.