

Case Number:	CM14-0025284		
Date Assigned:	06/11/2014	Date of Injury:	11/12/2008
Decision Date:	07/23/2014	UR Denial Date:	02/13/2014
Priority:	Standard	Application Received:	02/27/2014

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 is licensed to practice in Illinois. 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 43-year-old male who reported an injury on November 12, 2008. The mechanism of injury was the injured worker was hit by a falling box while at work. Prior treatment included a right knee arthroscopy, a partial meniscectomy on March 09, 2010 and a right knee medial and lateral meniscectomy, right knee tricompartmental synovectomy and chondroplasty on January 17, 2012. The injured worker additionally underwent an open reduction and internal fixation of the right proximal femur for a comminuted subtrochanteric and shaft fracture with trochanteric nail. The injured worker underwent an MRI of the left knee on December 30, 2011, which revealed a grade 1 signal seen within the posterior horn of the medial meniscus, there was no definitive tear. There was no ligament tear. There was mild effusion in the patellofemoral and suprapatellar bursa. There was no baker's/popliteal cyst or patellar chondromalacia present. The documentation of December 17, 2013 revealed the injured worker had complaints of neck pain rated 7/10, and left knee pain rated 6/10. It was indicated the injured worker was utilizing topical creams and had less pain. The injured worker complained of less pain with swelling in the left knee. There was tenderness to palpation over the medial joint line. There was decreased range of motion. There was crepitus. The motor strength was 4/5 on the right for hip flexors, knee extensors, great toe extensors and foot evertors. The strength on the left was 4+/5 for hip flexors and knee extensors, and 4-/5 for great toe extensors and foot evertors. The diagnoses included cervical disc syndrome, medial meniscus tear, left knee sprain and strain, and cervical disc disease. The treatment plan included an MRI of the cervical spine and acupuncture, topical creams, including TG Hot (tramadol 8%, gabapentin 10%, menthol 5, camphor 2%, capsaicin 0.05 %) 180gm, and FlurFlex (Flurbiprofen 10%, cyclobenzaprine 10%) 180gm, as well as tramadol 150mg (every 12 hours for pain), Relafen 750mg (1 tablet twice a day to reduce pain and inflammation), Prilosec 20mg (1 tablet twice a day to protect the stomach,

and a left knee arthroscopy). Additionally, there was a request for a preoperative medical clearance and postoperative physical therapy.

IMR ISSUES, DECISIONS AND RATIONALES

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

LEFT KNEE ARTHROSCOPY: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 343-345.

Decision rationale: The ACOEM Practice Guidelines indicate that a surgical consultation may be appropriate for injured workers who have documentation of activity limitation for more than 1 month and a failure of an exercise programs to increase range of motion and strength of the musculature around the knee. The clinical documentation submitted for review failed to provide documentation of the conservative care. Additionally, the request as submitted failed to indicate the specific procedure being requested. Given the above, the request for a left knee arthroscopy is not medically necessary.

PREOPERATIVE MEDICAL CLEARANCE: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

POSTOPERATIVE PHYSICAL THERAPY, QTY: 12.00: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

MRI OF THE CERVICAL SPINE: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-179.

Decision rationale: The ACOEM Practice Guidelines indicate the criteria for ordering imaging studies are the emergence of a red flag, physiologic evidence of tissue insult or neurologic dysfunction, failure to progress in a strengthening program intended to avoid surgery and clarification of the anatomy prior to an invasive procedure. There was a lack of documentation of objective findings upon physical examination and documentation that the injured worker had a failure to progress in a strengthening program intended to avoid surgery. Given the above, the request for an MRI of the cervical spine is not medically necessary.

ONE (1) PRESCRIPTION OF TG HOT (TRAMADOL 8%, GABAPENTIN 10%, MENTHOL 2%, CAMPHOR 2%, CAPSAICIN 0.05%) 180GM: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Tramadol, Gabapentin, Topical Capsaicin, Topical Analgesics, Topical Salicylates Page(s): 82, 113, 28, 111, 105. Decision based on Non-MTUS Citation FDA.gov.

Decision rationale: The California MTUS indicated that topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety and are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Guidelines also state that any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Topical Salicylates are recommended. A thorough search of FDA.gov, did not indicate there was a formulation of topical Tramadol that had been FDA approved. The approved form of Tramadol is for oral consumption, which is not recommended as a first line therapy. Gabapentin is not recommended. There is no peer-reviewed literature to support use. Capsaicin is recommended only as an option in patients who have not responded or are intolerant to other treatments. There have been no studies of a 0.0375% formulation of capsaicin and there is no current indication that this increase over a 0.025% formulation would provide any further efficacy. There was a lack of documentation of an objective decrease in pain and objective functional improvement. The duration of use could not be established through the supplied documentation. Since the guidelines do not recommend several of the ingredients, there is no medical necessity for this compound. Given the above, the request is not medically necessary.

ONE (1) PRESCRIPTION OF FLURFLEX (FLURBIPROFEN 10%, CYCLOBENZAPRINE 10%) 180GM: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines FLURBIPROFEN, TOPICAL ANALGESICS, CYCLOBENZAPRINE Page(s): 72, 111, 41. Decision based on Non-MTUS Citation National Library of Medicine - National Institute of Health (NLM-NIH) database.

Decision rationale: The California MTUS indicates 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. 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. This agent is not currently FDA approved for a topical application. 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 (NLM-NIH) database demonstrated no high quality human studies evaluating the safety and efficacy of this medication through dermal patches or topical administration. The California MTUS Guidelines do not recommend the topical use of Cyclobenzaprine as a topical muscle relaxants 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 clinical documentation submitted for review indicated the injured worker was utilizing topicals and receiving relief. However, there was a lack of documentation of objective functional improvement and documentation of objective pain relief. Additionally, the duration of use could not be established through the supplied documentation. There was a lack of documentation indicating a necessity for both topical and oral forms of NSAIDs. Given the above, the request is not medically necessary.

PRESCRIPTION OF RELAFEN 750MG: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Nabumetone Page(s): 72-73.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS Page(s): 67.

Decision rationale: The California MTUS Guidelines recommend NSAIDs for the short-term treatment of symptomatic pain. There should be documentation of objective functional improvement and an objective decrease in pain. The clinical documentation submitted for review failed to provide the duration of use for the requested medication. There was a lack of documentation of objective functional benefit and an objective decrease in pain. Given the above, the request is not medically necessary.

PRESCRIPTION OF PRILOSEC 20MG: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI Symptoms & Cardiovascular Risk Page(s): 68.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS Page(s): 69.

Decision rationale: The California MTUS Guidelines recommend PPIs for the treatment of dyspepsia secondary to NSAID therapy. The clinical documentation submitted for review indicated the injured worker was being given the medication as a stomach protectant. There was a lack of documentation indicating the injured worker had signs and symptoms of dyspepsia. The duration of use could not be established through the provided documentation. Given the above, the request is not medically necessary.

ONE (1) PRESCRIPTION OF TRAMADOL 150MG (#60): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids (Ultram) Page(s): 78, 93-94.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Medications for Chronic pain, ongoing management Page(s): 60, 78.

Decision rationale: The California MTUS Guidelines recommend opiates for the treatment of dyspepsia secondary to NSAID therapy. There should be documentation of an objective decrease in pain, objective increase in function, and documentation the injured worker is being monitored for aberrant drug behavior and side effects. The clinical documentation submitted for review failed to meet the above recommendations. The duration of use could not be established through the submitted documentation. Given the above, the request is not medically necessary.