

Case Number:	CM14-0026016		
Date Assigned:	06/13/2014	Date of Injury:	12/14/2011
Decision Date:	12/16/2014	UR Denial Date:	02/06/2014
Priority:	Standard	Application Received:	02/28/2014

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 Connecticut. 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 56-year-old female who reported an injury on 12/14/2011. The mechanism of injury was not provided. The injured worker's diagnoses included anterior cruciate ligament and instability of the left knee. The injured worker's past treatments included physical therapy, injections, and medications. The injured worker's diagnostic studies included x-rays of the right knee and right tibia, which showed no increase of osteoarthritis. The injured worker's surgical history included a left knee anterior cruciate ligament reconstruction with anterior tibialis allograft and partial medial meniscectomy performed on 04/08/2014. On 06/11/2014, the injured worker reported that she noticed a decrease in popping. She rated her pain level a 3/10 on the pain scale. Upon physical examination, the injured worker was noted to receive her third out of a 5 series of hyalgan injections to the right knee. The patient reported that the injections are helping a bit. The injured worker's current medications were not included in the documentation. The request was for Dyotin 25/10 mg, Flurbiprofen 100/100 mg, Flurbiprofen Theraflex Transdermal Cream, Keratek gel 4 oz., and Hydrocodone 10/300/2 mg. The rationales for the requests were not provided. The Request for Authorization form was not submitted for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Dyotin 250/10mg Capsule #60 (Gabapentin): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Gabapentin Page(s): 18-19.

Decision rationale: The request for Dyotin 250/10mg capsule #60 (Gabapentin) is not medically necessary. According to the California MTUS Guidelines, Gabapentin has shown to be effective for the treatment of diabetic painful neuropathy and post herpetic neuralgia and has been considered as a first line treatment for neuropathic pain. It has been given FDA approval for treatment of post-herpetic neuralgia. There is limited evidence to show that this medication is effective for postoperative pain. The injured worker reported postoperative knee pain that she rated 3/10 on a pain scale. The documentation did not indicate the patient had post herpetic neuralgia, or diabetic neuropathy. Documentation of that would include a complete and thorough pain assessment to include the least reported pain over the period since last assessment; intensity of pain after taking the opioid; and how long pain relief lasts. In the absence of documentation with significant objective functional limitations, a complete and thorough pain assessment, documented evidence of post-herpetic neuralgia or diabetic neuropathy conditions, the requests is not supported. Additionally, as the request was written, there was no frequency provided. As such, the request is not medically necessary.

Flurbitac 100/100mg Capsules #60 (Flurbiprofen): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Flurbiprofen Page(s): 72.

Decision rationale: The request for Flurbitac 100/100mg capsules #60 (Flurbiprofen) is not medically necessary. According to California MTUS Guidelines Flurbiprofen may be indicated or arthritis and mild to moderate pain. The maximum daily dose is 300 mg per day. NSAIDs may be recommended for osteoarthritis of the knee at the lowest dose at the shortest period in patients with moderate to severe pain. Acetaminophen may be considered for initial therapy for patients with mild to moderate pain. There is no evidence of long term effectiveness for pain or function. The injured worker complained of knee pain that she rated at 3/10 on a pain scale. The documentation did not include a complete and thorough pain assessment to include the least reported pain over the period since last assessment; intensity of pain after taking the medication; and how long pain relief lasts. The documentation did not provide evidence of significant objective functional limitations. The documentation did not indicate how long the patient has been using this medication, as the guidelines recommend it be used for the shortest period in patients with moderate to severe pain. In the absence of documentation with sufficient evidence of significant objective functional limitations, documented evidence of a complete and thorough pain assessment, documented evidence of the length of time the patient has been using the medication, the request is not supported. Additionally, as the request was written, there was no frequency provided. Therefore, the request is not medically necessary.

Theraflex Transdermal Cream 20%/10%/4% (Flurbiprofen): 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 Page(s): 111-113.

Decision rationale: The request for Theraflex transdermal cream 20%/10%/4% (Flurbiprofen) is not medically necessary. According to the California MTUS Guidelines, 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. 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 the agents. Any compounded product that contains at least 1 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 therapeutically required. The efficacy of topical NSAIDs in clinical trials 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 indications for the use of topical NSAIDs are osteoarthritis and tendinitis of the knee and other joints that can be treated topically. They are recommended for short term use of 4 to 12 weeks. The injured worker reported knee pain that she rated a 3/10 on a pain scale. The documentation did not include a complete and thorough pain assessment to include the least reported pain over the period since last assessment; intensity of pain after taking the medication; and how long pain relief lasts. The documentation did not provide sufficient evidence of significant objective functional limitations. In the absence of documentation with sufficient evidence of significant objective functional limitations, documented evidence of a complete and thorough pain assessment, 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 4oz: 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 Salicylates, Topical Analgesics Page(s): 105, 111.

Decision rationale: The request for Keratek gel 4oz is not medically necessary. The California MTUS Guidelines state that topical salicylate is significantly better than placebo and 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 1 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 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 was written, there was no frequency provided. Therefore, the request is not medically necessary.

Vicose tron Capsules 10/300/2mg #60 (Hydrocodone): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 78-83.

Decision rationale: The request for Vicose tron capsules 10/300/2mg #60 (hydrocodone) is not medically necessary. According to the California MTUS Guidelines, hydrocodone is often used for intermittent or breakthrough pain. It is not recommended as a first line therapy for osteoarthritis. It may be recommended on a trial basis for short term use after there has been evidence of failure of first line nonpharmacologic and medication options and when there is evidence of moderate to severe pain. The injured worker reported a 3/10 on a pain scale. The documentation did not include a complete and thorough pain assessment to include the least reported pain over the period since last assessment; intensity of pain after taking the medication; and how long pain relief lasts. The documentation did not provide sufficient evidence of significant objective functional limitations. The documentation did not indicate how long the patient has been using this medication or the efficacy of the medication. The documentation did not include ongoing review, documentation of pain relief due to the medications, side effects, physical, and psychosocial functioning, and the occurrence of any potentially aberrant drug related behaviors. In the absence of documented evidence of a complete and thorough pain assessment, along with documentation of sufficient evidence of significant objective functional limitations, documented evidence of a complete and thorough pain assessment, and documented evidence of how long the medication has been in use, and the efficacy of the medication. The request is not supported. Additionally, as the request was written, there was no frequency provided. Therefore, the request is not medically necessary.