

Case Number:	CM14-0034217		
Date Assigned:	06/20/2014	Date of Injury:	05/15/1977
Decision Date:	08/13/2014	UR Denial Date:	02/24/2014
Priority:	Standard	Application Received:	03/19/2014

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 and Washington. 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 60-year-old male who reported an injury on 05/15/1977 due to a twisting injury of his left knee. On 01/08/2014, the injured worker presented with left knee pain. Upon examination of the left knee, there was mild tissue swelling and pain elicited to completion over the medial joint line. There was also mild patellar crepitus present. There was a positive Steinmann, compression and distraction test noted. The diagnoses were clinical evidence of a recurrent medial meniscus tear of the left knee. Medication list was not provided. The provider recommended Theraflex transdermal cream and Keratek gel. The provider's rationale was not provided. The request for authorization form was dated 01/22/2014.

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% (Flurbiprofen): 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 Topical Analgesics Page(s): 111.

Decision rationale: The request for Theraflex transdermal cream is not medically necessary. The California MTUS states that topical analgesia are experimental in use and there are few

randomized control trials to determine efficacy or safety. It is 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 a placebo during the first 2 weeks of treatment for osteoarthritis, but with diminishing effect over a 2 week period. Flurbiprofen is classified as a nonsteroidal anti-inflammatory agent. This agent is not currently FDA approved for topical application. The FDA approved routes of administration for Flurbiprofen include oral tablets and ophthalmologic solution. The California MTUS Guidelines do not recommend the topical use of cyclobenzaprine as a topical muscle relaxant, as there is no evidence for use of any other muscle relaxant as a topical product. The addition of cyclobenzaprine or any other agent is not recommended. Additionally, the provider does not indicate frequency or dose of the Theraflex cream that is intended for within the request as submitted. As such, the request is not medically necessary.

Keratek Gel 4oz: 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 Topical Analgesics, page(s) 111 and Salicylate topicals, page(s) 105 Page(s): 111, 105.

Decision rationale: The request for Keratek gel 4 ounces is not medically necessary. California MTUS states topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. It is primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. There is little to no research to support the use of any of these agents. Any compounded product that contains at least 1 drug or drug class that is not recommended, it is not recommended. Guidelines state that salicylate topicals are recommended and is significantly better than placebo in chronic pain. However, the provider's request did not indicate the dose, frequency, or site the Keratek gel is intended for within the request. As such, the request is not medically necessary.