

Case Number:	CM14-0066125		
Date Assigned:	07/11/2014	Date of Injury:	02/02/2013
Decision Date:	08/27/2014	UR Denial Date:	04/09/2014
Priority:	Standard	Application Received:	05/09/2014

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 & Rehab and is licensed to practice in Nevada. 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 records presented for review, indicate that this 24-year-old male was reportedly injured on 2/2/2013. The mechanism of injury was noted as a work-related injury when the claimant's knee struck the wall. The most recent progress note, dated 3/17/2014, indicated that there were ongoing complaints of left knee pain. The physical examination demonstrated left knee range of motion 0-125, positive medial joint line tenderness and mild swelling. No recent diagnostic studies are available for review. Previous treatment included arthroscopic surgery, physical therapy #8 visits, and medications. A request was made for postoperative physical therapy of the left knee, #8 visits, FluriFlex cream 180 gm, TGHOT cream 180 gm and was not certified in the pre-authorization process on 4/9/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

ADDITIONAL 8 VISITS OF POST-OP PT FOR THE LEFT KNEE: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES, POST OP PT.

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 24.

Decision rationale: Postsurgical treatment guidelines recommend therapy after surgery. Arthroscopic postsurgical treatment included 12 visits over 12 weeks. After review of the medical records provided, the injured worker has had eight previous physical therapy visits. The current request of additional visits exceeded the maximum amount of therapy for this procedure. Without supporting documentation or extenuating circumstances for the need of additional therapy, this request is deemed not medically necessary.

FLURIFLEX (FLURBIPROFEN/CYCLOBENZAPRINE 15/10%) CREAM 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 Page(s): 111-113.

Decision rationale: FluriFlex (Flurbiprofen/Cyclobenzaprine 15/10%) Cream: MTUS Chronic Pain Guidelines state that topical analgesics are largely experimental, and any compound product, that contains at least one drug (or drug class), that is not recommended is not recommended. The guidelines note there is little evidence to support the use of topical non-steroidal anti-inflammatory medications (NSAIDs) (Flurbiprofen) for treatment of osteoarthritis of the spine, hip or shoulder and there is no evidence to support the use for neuropathic pain. Additionally, the guidelines state there is no evidence to support the use of Topical Cyclobenzaprine (a muscle relaxant). The guidelines do not support the use of Flurbiprofen or Cyclobenzaprine in a topical formulation. Therefore, the request is deemed not medically necessary.

TGHOT (TRAMADOL/GABAPENTIN/MENTHOL/CAMPHOR/CAPSAICIN 8/10/2/2/.05%) CREAM 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 Page(s): 111-113.

Decision rationale: Tramadol/Gabapentin/Menthol/Camphor/Capsaicin 8/10/2/0.05%. Cream: MTUS Chronic Pain Guidelines state that topical analgesics are largely experimental, and any compound product that contains at least one drug (or drug class), that is not recommended, is not recommended. The guidelines indicate Gabapentin is not recommended for topical application. Additionally, the guidelines recommend the use of Capsaicin only as an option for patients who are intolerant of other treatments and there is no indication that an increase over a 0.025% formulation would be effective. There is no documentation in the records submitted indicating the claimant was intolerant of other treatments. The request for topical TGHot is not in accordance with the MTUS Guidelines. Therefore, the request for TGHot Cream is not medically necessary.

