

Case Number:	CM14-0066629		
Date Assigned:	08/08/2014	Date of Injury:	11/20/2006
Decision Date:	12/19/2014	UR Denial Date:	05/08/2014
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 Occupational Medicine 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 60-year-old female who has submitted a claim for status post left knee total knee replacement, right knee internal derangement, lumbar disc herniation with radiculopathy, and GERD associated with an industrial injury date of 11/20/2006. Medical records from 2014 were reviewed. The patient complained of low back, rated 7/10 in severity, radiating to the right lower extremity. She likewise complained of bilateral knee pain associated with numbness and tingling sensation. Moreover, she experienced anxiety, depression, stress, and insomnia. Medications provided 50% to 60% symptom relief with noted improvement in activities of daily living. Examination of the right knee revealed swelling, warmth, tenderness, and spasms. Range of motion of both knees was restricted. Effusion was also noted. Treatment to date has included left total knee replacement in 2012, physical therapy, Percocet, Flexeril, omeprazole, and Relafen (since 2013). The utilization review from 5/8/2014 denied the request for comprehensive metabolic panel test because patient was recently certified on 4/1/2014 to undergo testing and there was no rationale for repeat testing at this time; denied Flexeril 10mg, #90 because long term use was not recommended; denied Prilosec 20mg, #60; denied because of no gastrointestinal risk factor present; and denied the requests for flurbiprofen 20% cream 120gm, ketoprofen 20% + ketamine 10% cream 120gm, and gabapentin 10% + cyclobenzaprine 10% with 0.375% capsaicin cream 120 gm because of limited published studies concerning its efficacy and safety.

IMR ISSUES, DECISIONS AND RATIONALES

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

Comprehensive metabolic panel test: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation
[HTTP://WWW.LABTESTSONLINE.ORG/UNDERSTANDING/ANALYTES/CMP/GLANCE.HTML](http://www.labtestsonline.org/understanding/analytes/cmp/glance.html)

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Laboratory Safety Monitoring of Chronic Medications in Ambulatory Care Settings
<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1490088>

Decision rationale: The CA MTUS does not address this topic. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, the Journal of General Internal Medicine was used instead. Literature concludes that a large proportion of patients receiving selected chronic medications do not receive recommended laboratory monitoring in the outpatient setting. In this case, there are no known comorbid conditions. There is no documented rationale for this request. The present request as submitted also failed to specify the laboratory tests to be included. Therefore, the request for comprehensive metabolic panel test is not medically necessary.

Flexeril 10mg Qty: 90: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Cyclobenzaprine Page(s): 41-42.

Decision rationale: According to page 41-42 of the CA MTUS Chronic Pain Medical Treatment Guidelines, sedating muscle relaxants are recommended with caution as a second-line option for short-term treatment of acute exacerbations in patients with chronic low back pain. In this case, the patient has been on Flexeril since 2013. She reports 50% to 60% symptom relief with improvement in activities of daily living upon its use. However, long-term use of muscle relaxant is not guideline recommended. Therefore, the request for Flexeril 10mg, #90 is not medically necessary.

Prilosec 20mg Qty: 60: Overturned

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS, GI Symptoms, and Cardiovascular Risk Page(s): 68.

Decision rationale: As stated on page 68 of CA MTUS Chronic Pain Medical Treatment Guidelines, clinicians should weigh the indications for NSAIDs against both GI and cardiovascular risk factors: age > 65 years, history of peptic ulcer, GI bleeding or perforation; concurrent use of ASA, corticosteroids, or anticoagulant; or on high-dose/multiple NSAIDs. Patients with intermediate risk factors should be prescribed proton pump inhibitors (PPI). In this case, the patient has been on omeprazole since 2013 as treatment for gastroesophageal reflux disease. The medical necessity for PPI use has been established. Therefore, the request for Prilosec 20mg, #60 is medically necessary.

Flurbiprofen 20% cream 120gm: 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: As stated on pages 111-113 of the California MTUS Chronic Pain Medical Treatment Guidelines, topical analgesics are largely experimental in use with few randomized controlled trials to determine safety or efficacy. Topical NSAIDs formulation is only supported for diclofenac in the California MTUS. In addition, there is little to no research as for the use of flurbiprofen in compounded products. In this case, topical cream is prescribed as adjuvant therapy to oral medications. However, the prescribed medication is not recommended for topical use. Guidelines state that any compounded product that contains a drug class, which is not recommended, is not recommended. Therefore, the request for flurbiprofen 20% cream 120gm is not medically necessary.

Ketoprofen 20% + Ketamine 10% cream 120gm: 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): 111-113.

Decision rationale: As stated on pages 111-113 of the California MTUS Chronic Pain Medical Treatment Guidelines, topical analgesics are largely experimental in use with few randomized controlled trials to determine safety or efficacy. Ketoprofen is not recommended for topical use as there is a high incidence of photo contact dermatitis. Ketamine is only recommended for treatment of neuropathic pain in refractory cases in which all primary and secondary treatment has been exhausted. In this case, topical cream is prescribed as adjuvant therapy to oral medications. However, the prescribed medication contains ketoprofen, which is not recommended for topical use. Guidelines state that any compounded product that contains a drug class, which is not recommended, is not recommended. Therefore, the request for ketoprofen 20% + ketamine 10% cream 120gm is not medically necessary.

Gabapentin 10% + Cyclobenzaprine 10% with 0.375% capsaicin cream 120 gm: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Capsaicin, Topical Analgesics Page(s): 111-113 28.

Decision rationale: As stated on pages 111-113 of the California MTUS Chronic Pain Medical Treatment Guidelines, topical analgesics are largely experimental in use with few randomized controlled trials to determine safety or efficacy. CA MTUS Chronic Pain Medical Treatment Guidelines identifies on page 28 that topical Capsaicin is only recommended as an option if there was failure to respond or intolerance to other treatments. The guideline states there is no current indication that an increase over a 0.025% formulation of capsaicin would provide any further efficacy. CA MTUS does not support the use of opioid medications and gabapentin in a topical formulation. Cyclobenzaprine is not recommended for use as a topical analgesic. In this case, topical cream is prescribed as adjuvant therapy to oral medications. However, the prescribed medication contains cyclobenzaprine, gabapentin, and capsaicin in 0.375% formulation, which are not recommended for topical use. Guidelines state that any compounded product that contains a drug class, which is not recommended, is not recommended. Therefore, the request for gabapentin 10% + cyclobenzaprine 10% with 0.375% capsaicin cream 120 gm is not medically necessary.