

<b>Case Number:</b>	CM14-0070525		
<b>Date Assigned:</b>	07/14/2014	<b>Date of Injury:</b>	07/12/2011
<b>Decision Date:</b>	08/14/2014	<b>UR Denial Date:</b>	04/15/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/15/2014

### 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, has a subspecialty in Interventional Spine 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 63-year-old male with a date of injury of 07/12/2011. The listed diagnosis per [REDACTED] is isolated medial compartment osteoarthritis of the left knee. The patient underwent a diagnostic and operative arthroscopy performed in September 2012. According to progress report 04/02/2014 by [REDACTED], the patient presents with complaints of severe left knee pain with grinding, catching, and locking. Examination revealed well-healed arthroscopic portal incisions about the knee and moderate intraarticular effusion. There is marked tenderness about the knee medially. An X-ray of the knee and tibia showed severe loss of the medial compartment on standing views. The medical file provided for review includes one initial orthopedic evaluation report by [REDACTED]. This report provides no discussion on the requested medications. This is a request for Dyotin 250/10 mg #60, Flubitac 100 mg #60, Theraflex transdermal cream, and Keratek gel 4-ounce bottle. Utilization review did not grant the request on 04/15/2014.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Dyotin 250/10 Quantity 60:** 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 Gabapentin (Neurontin®, Gabarone™, generic available), Gabapentin (Neurontin®) page 18-19, 49.

**Decision rationale:** This patient is status post diagnostic and operative arthroscopy from 2012 and continues to remain symptomatic with pain, grinding, catching, and locking. The request is for Dyotin 250/10 #60. Dyotin contains gabapentin and pyridoxine. Utilization review did not grant the request stating the patient does not have a vitamin B6 deficiency to indicate the need for pyridoxine. The MTUS Guidelines page 18 and 19 has the following regarding Gabapentin; Gabapentin has been shown to be effective for treatment of diabetic painful neuropathy and post-therapeutic neuralgia and has been considered a first-line treatment for neuropathic pain. In this case, the patient does not present with neuropathic pain and the Gabapentin contained in Dyotin is not indicated. Therefore, the request is not medically necessary.

**Flubitac 100/100mg Quantity 60:** 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, Chronic Pain Section page 111.

**Decision rationale:** This patient is status post diagnostic and operative arthroscopy from 2012 and continues to remain symptomatic with pain, grinding, catching, and locking. The request is for Flubitac 100mg #60. The ACOEM, MTUS and ODG do not specifically discuss Flubitac. Flubitac is a compound medication that contains Flurbiprofen 100mg and Ranitidine 100mg. For Flurbiprofen, MTUS states, the efficacy in clinical trials for this treatment modality has been inconsistent, and most studies are small and of short duration. Topical NSAIDs had been shown in the meta-analysis to be superior to placebo during the first 2 weeks of treatment for osteoarthritis. For Ranitidine, MTUS recommends determining risk for GI events before prescribing prophylactic PPI or omeprazole. The MTUS further states, any compounded product that contains at least one (or drug class) that is not recommended is not recommended. In this case, Flurbiprofen may be indicated for the patient's osteoarthritis, but the provider provides no discussion of GI issues warranting the medication Ranitidine. Therefore, the request is not medically necessary.

**Theraflex transdermal cream 20%/10%/4%:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics. Decision based on Non-MTUS Citation Official Disability Guidelines Pain Chapter.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics, Chronic Pain Section, page 111.

**Decision rationale:** This patient is status post diagnostic and operative arthroscopy from 2012 and continues to remain symptomatic with pain, grinding, catching, and locking. The request is for Theraflex transdermal cream. Theraflex transdermal cream contains Flurbiprofen, Cyclobenzaprine and menthol. The MTUS Guidelines p 111 has the following regarding topical creams, topical analgesics are largely experimental and used with few randomized control trials

to determine efficacy or safety. The MTUS further states, any compounded product that contains at least one (or drug class) that is not recommended is not recommended. In this case, Cyclobenzaprine is a muscle relaxant and is not recommended for any topical formulation. Therefore, the request is not medically necessary.

**Keratek gel 4 oz bottle:** Overturned

**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, Chronic Pain Section, page 111.

**Decision rationale:** This patient is status post diagnostic and operative arthroscopy from 2012 and continues to remain symptomatic with pain, grinding, catching, and locking. The request is for Keratek gel 4oz bottle. Keratek is a compound gel that contains methyl salicylate and menthol. Utilization review did not grant the request stating, the patient has not failed the OTC ben-gay to indicate the need for prescription strength. The MTUS Guidelines allows for the use of topical NSAID for peripheral joint arthritis and tendonitis. This patient does present with osteoarthritis of the knee. Therefore, the request is medically necessary.





