

Case Number:	CM14-0072215		
Date Assigned:	07/16/2014	Date of Injury:	04/08/2010
Decision Date:	09/03/2014	UR Denial Date:	04/29/2014
Priority:	Standard	Application Received:	05/19/2014

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, has a subspecialty in and is licensed to practice in Texas and Oklahoma. 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 55-year-old male who reported an injury on 04/08/2011 due to an unknown mechanism. Diagnoses were status post total right knee replacement, status post left knee arthroscopy with medial and lateral meniscectomy, and lumbar disc syndrome. Past treatments were physical therapy and home exercise. Diagnostic studies were MRI of the right knee, MRI of the cervical spine, MRI of the lumbar spine, and MRI of the left knee on 03/08/2014. Surgical history was surgery of the right knee in 1982 and 2007, left elbow surgery 1990, appendectomy 1992, total right knee replacement 2012, left shoulder surgery 2012, and left knee internal repair on 05/23/2014. The injured worker had a physical examination on 06/03/2014 with complaints of ongoing bilateral knee pain; right knee was rated at 8/10 and the left knee had pain rated 6/10. Low back pain was rated as 6/10. Examination of the lumbar spine revealed palpation elicited tenderness of the paralumbar muscles bilaterally. Flexion was to 50 degrees, extension was to 15 degrees, lateral flexion to the right was to 15 degrees, and lateral flexion to the left was 15 degrees. Range of motion of the lumbar spine was painful at the terminal ranges. Range of motion for right knee flexion was to 130 degrees; left knee flexion was to 120 degrees. No extension was reported bilaterally. Range of motion for the left knee was limited. Medications were TGH cream, FluriFlex ointment, Relafen, and tramadol ER. Treatment plan was for a course of postoperative physical therapy, neurosurgical spine consultation, and to take medications as directed. The rationale and request for authorization were not submitted for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI of the left shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 208-209. Decision based on Non-MTUS Citation Official Disability Guidelines, shoulder (acute and chronic).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 201.

Decision rationale: The request for MRI of the left shoulder is not medically necessary. The ACOEM recommends that for MRI of the shoulder there should be symptoms of pain over the deltoid area with overhead work. Also, there should be weakness on elevation and external rotation of the shoulder. Unique signs of weakness of shoulder in thumbs down abduction or weak external rotation would indicate the need for further testing. For suspected rotator cuff tears with the unique symptoms and signs, MRI would be indicated for younger workers preoperatively only. For unique signs and unique symptoms, if MRI unavailable, arthrography would be indicated only preoperatively. For unique symptoms of pain with movement or unique signs of instability, MRI would be indicated for possible labral tear. For unique symptoms of night pain and shoulder joint with lack of range of motion and unique signs of limited passive range of motion, MRI would be indicated for possibility of adhesive capsulitis. There were no recent reports of physical therapy for the left shoulder. The physical findings and examination do not meet the criteria set forth by the medical guidelines. Therefore, the request is not medically necessary.

TGHot (Tramadol 8%, Gabapentin 10%, Menthol 2%, Camphor 2%, Capsaicin 0.5 %) 180 gm: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, shoulder (acute and chronic), page 33.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111, 112.

Decision rationale: The request for TGHot (tramadol 8%, gabapentin 10%, menthol 2%, camphor 2%, capsaicin 0.5%) 180 grams is not medically necessary. The California Medical Treatment Utilization Schedule states topical analgesics are recommended as an option. They 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. There is little to no research to support the use of many of these agents. Any compounded product that contains at least 1 drug (or drug class) that is not recommended is not recommended. This medication is a compounded medication. It contains capsaicin which is recommended only as an option in patients who have not responded or are intolerant to other treatments. Capsaicin is generally available as a 0.025% formulation (as a treatment for osteoarthritis) and a 0.075% formulation (primarily studied for postherpetic

neuralgia, diabetic neuropathy, and post-mastectomy pain). There have been no studies of a 0.0375% formulation of capsaicin and there is no current indication that this increase over a 0.025% formulation would provide any further efficacy. Another ingredient in this medication is gabapentin which is not recommended. Due to the fact that this is a compounded medication and the guidelines do not support the use of this, the request is not medically necessary.

Flurflex (Flurbiprofen 10%, Cyclobenzaprine 10%) 180 gm: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, shoulder (acute and chronic).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111, 112.

Decision rationale: The request for FluriFlex (flurbiprofen 10%, cyclobenzaprine 10%) 180 grams is not medically necessary. The California Medical Treatment Utilization Schedule states topical analgesics are recommended as an option. They 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. There is little to no research to support the use of many of these agents. Any compounded product that contains at least 1 drug (or drug class) that is not recommended is not recommended. There was no evidence for use of any other muscle relaxant as a topical product. This medication contains cyclobenzaprine which is a muscle relaxant. It is not recommended for use by the guidelines. This medication is also a compounded medication which is not supported by the medical guidelines for use. The request does not indicate a frequency for the medication. Therefore, the request is not medically necessary.

Urine drug screen: 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 On Going Management Page(s): 78.

Decision rationale: The request for urine drug screen is not medically necessary. The California Medical Treatment Utilization Schedule indicates that the use of urine drug screening is for patients with documented issues of abuse, addiction, or poor pain control. It was not reported that the injured worker was taking any type of an opioid medication. There were no reports of active signs of misuse for medication. Therefore, the request is not medically necessary.