

Case Number:	CM15-0019892		
Date Assigned:	02/11/2015	Date of Injury:	09/26/2010
Decision Date:	04/06/2015	UR Denial Date:	01/20/2015
Priority:	Standard	Application Received:	02/02/2015

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: California, Washington

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Pain Management

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 female with reported date of injury on 09/06/2010; the mechanism of injury is not provided. The injured worker's diagnoses include patellofemoral pain and osteoarthritis. The prior treatments have included medications, physical therapy, injections, and activity restriction. The injured worker was noted to have undergone total knee arthroplasty due to severe tricompartmental osteoarthritis on 05/13/2013. A progress note dated 08/29/2013 indicated that the injured worker had continued complaints of sharp pain in the left knee rated 6/10. There was no physical examination provided; however, it was noted that x-rays were taken of the left knee. This imaging study was noted to reveal no increase of osteoarthritis. Under the treatment plan, the physician provided the injured worker with Theraflex cream 180 mg and Bio-Therm pain relieving lotion 4 oz bottle.

IMR ISSUES, DECISIONS AND RATIONALES

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

Flurb/Cyclo/Menthol Cream 20% 10% 4% 180gm,: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Flurbiprofen; Topical analgesics; Cyclobenzaprine; Salicylate Topicals Page(s): 72; 111; 41; 105.

Decision rationale: According to the California MTUS Treatment Guidelines, topical analgesics are largely experimental; however, may be recommended in patients for treatment of neuropathic pain when trials of antidepressants and anticonvulsants have failed. In addition, the guidelines continue to state that any compounded product that contains at least 1 drug or drug class that is not recommended, the entire product is therefore not recommended. The guidelines also state that topical NSAIDs have been shown in meta-analysis to be superior to placebo during the first 2 weeks of treatment for osteoarthritis. However, flurbiprofen is not currently FDA approved for topical application. The current FDA approved route of administration for flurbiprofen include oral tablets and ophthalmologic solution. Additionally, the National Library of Medicine - National Institutes of Health database demonstrated no high quality human studies evaluating the safety and efficacy of this medication for topical administration. Furthermore, the guidelines do not currently recommend topical use of cyclobenzaprine as a topical muscle relaxant as there is no evidence for use of this or any other muscle relaxant in a topical solution. This requested compound medication cannot be supported. There is lack of documentation that the injured worker suffers from neuropathic pain or has failed to respond to trial of antidepressants and anticonvulsants. Additionally, this compounded medication contains non-approved forms of medication. Therefore, the requested Flurb/Cyclo/Menthol Cream 20% 10% 4% 180gm is considered not medically necessary.

Keratek Gel (Methyl/Salicylate/Menthol 4oz bottle): 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 Salicylates; Topical Analgesics Page(s): 105; 111.

Decision rationale: According to the California MTUS Guidelines, salicylate topical medications are currently recommended as they have been shown to be significantly better than placebo for treatment of chronic pain. Although the use of topical salicylate medications is currently supported by the guidelines, there is lack of rationale for the use of this medication to include frequency, duration, and location of use. Therefore, the requested Keratek gel (Methyl/Salicylate/Menthol) 4 oz bottle is not medically necessary.