

Case Number:	CM15-0184722		
Date Assigned:	09/25/2015	Date of Injury:	11/16/2010
Decision Date:	11/23/2015	UR Denial Date:	08/18/2015
Priority:	Standard	Application Received:	09/21/2015

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

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 42 year old male, who sustained an industrial injury on 11-16-2010. The injured worker is being treated for joint pain leg. Treatment to date has included anti-inflammatory medications, physical therapy, icing and bracing. Per the Primary Treating Physician's Progress Report dated 7-22-2015 the injured worker presented for follow-up for his right knee. He reported that he continues to experience pain to the knee, described as unchanged. Objective findings included global tenderness about the right knee. There is pain elicited to palpation over the medial joint line. X-rays were reviewed and read as "progressive degenerative arthritis of the medial compartment." Work status was return to full duty as of 7-23-2015. The plan of care included Supartz injections and medications, and authorization was requested on 8-11-2015 for Orphenadrine 50mg-caffeine 10mg #60, Flurbiprofen-Omeprazole 100-10mg #60, Flurb-Cyclo-Menth cream 20% 180gm, Keratek gel 4 oz. bottle, and Mometasone/Doxepin 15%-5%. On 8-18-2015, Utilization Review non-certified the request for Orphenadrine 50mg-caffeine 10mg #60, Flurbiprofen-Omeprazole 100-10mg #60, Flurb-Cyclo-Menth cream 20% 180gm, Keratek gel 4 oz. bottle, and Mometasone/Doxepin 15%-5%.

IMR ISSUES, DECISIONS AND RATIONALES

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

Orphenadrine 50mg/Caffeine 10mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Muscle relaxants (for pain).

Decision rationale: Regarding the request for orphenadrine (Norflex), Chronic Pain Medical Treatment Guidelines support the use of nonsedating muscle relaxants to be used with caution as a 2nd line option for the short-term treatment of acute exacerbations of pain. Guidelines go on to state that orphenadrine specifically is recommended for a short course of therapy. Within the documentation available for review, there is no identification of a specific analgesic benefit or objective functional improvement as a result of the orphenadrine. Additionally, it does not appear that this medication is being prescribed for the short-term treatment of an acute exacerbation, as recommended by guidelines. Finally, there is no documentation of failure of first-line treatment options, as recommended by guidelines. Additionally, it is unclear why caffeine is needed in addition to Orphenadrine. In the absence of clarity regarding those issues, the currently requested orphenadrine (Norflex) is not medically necessary.

Flurb/Omeprazole 100/10mg, #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): NSAIDs (non-steroidal anti-inflammatory drugs).

Decision rationale: Regarding the request for Flurb/Omeprazole 100/10mg, #60, Chronic Pain Medical Treatment Guidelines state that NSAIDs are recommended at the lowest dose for the shortest period in patients with moderate to severe pain. Within the documentation available for review, there is no indication that Naproxen is providing any specific analgesic benefits (in terms of percent pain reduction, or reduction in numeric rating scale), or any objective functional improvement. In the absence of such documentation, the currently requested Flurb/Omeprazole 100/10mg, #60 is not medically necessary.

Flurb/Cyclo/Menth cream 20%/10/4%, 180gm: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Topical Analgesics.

Decision rationale: Regarding the request for Flurb/Cyclo/Menth cream 20%/10/4%, 180gm, CA MTUS states that topical compound medications require guideline support for all components of the compound in order for the compound to be approved. Muscle relaxants drugs

are not supported by the CA MTUS for topical use. As such, the currently requested Flurb/Cyclo/Menth cream 20%/10/4%, 180gm is not medically necessary.

Kera Tek gel, 4 oz bottle: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Topical Analgesics.

Decision rationale: Regarding the request for Kera-tek gel, guidelines state that topical NSAIDs are recommended for short-term use. Oral NSAIDs contain significantly more guideline support, provided there are no contraindications to the use of oral NSAIDs. Within the documentation available for review, there's no indication that the patient has obtained any specific analgesic effect (in terms of percent reduction in pain, or reduced NRS) or specific objective functional improvement from the use of Kera-tek gel. Additionally, there is no documentation that the patient would be unable to tolerate oral NSAIDs, which would be preferred, or that the Kera-tek gel is for short term use, as recommended by guidelines. In the absence of clarity regarding those issues, the currently requested Kera-tek gel is not medically necessary.

Mometasone/Doxepin .15%/5%: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Topical Analgesics.

Decision rationale: Regarding the request for Mometasone/Doxepin 15%/5%, CA MTUS states that topical compound medications require guideline support for all components of the compound in order for the compound to be approved. Guidelines do not support the use of topical antidepressants. As such, the currently requested Mometasone/Doxepin 15%/5% is not medically necessary.