

<b>Case Number:</b>	CM15-0218302		
<b>Date Assigned:</b>	11/10/2015	<b>Date of Injury:</b>	05/27/2013
<b>Decision Date:</b>	12/21/2015	<b>UR Denial Date:</b>	10/27/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/05/2015

### 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: Emergency Medicine

### 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 65 year old female, who sustained an industrial injury on 5-27-13. She reported knee pain. The injured worker was diagnosed as having right knee pain secondary to compensatory factors, left knee meniscal tear, status post left knee arthroscopy, and posttraumatic osteoarthritis of the left knee. Treatment to date has included a home exercise program and medication including Naprosyn. Physical exam findings on 9-2-15 included medial right knee tenderness. McMurray's test was positive and range of motion was 0 to 130 degrees. Mild effusion was noted. Bilateral lower extremities were noted to be neurologically normal. On 9-2-15, the injured worker complained of bilateral knee pain. Right knee pain was rated as 7 of 10. The treating physician requested authorization for Flurbiprofen 20%-Cyclobenzaprine 10%-Menthol cream 4% 180g and a MRI of the right knee. On 10-27-15 the requests were non-certified by utilization review.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Flurbiprofen 20%/Cyclobenzaprine 10%/Menthol Cream 4% 180gm: Upheld**

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

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

**Decision rationale:** The requested Flurbiprofen 20%/Cyclobenzaprine 10%/Menthol Cream 4% 180gm, is not medically necessary. California Medical Treatment Utilization Schedule (MTUS), 2009, Chronic pain, page 111-113, Topical Analgesics, do not recommend topical analgesic creams as they are considered "highly experimental without proven efficacy and only recommended for the treatment of neuropathic pain after failed first-line therapy of antidepressants and anticonvulsants". The injured worker has right knee pain secondary to compensatory factors, left knee meniscal tear, status post left knee arthroscopy, and posttraumatic osteoarthritis of the left knee. Treatment to date has included a home exercise program and medication including Naprosyn. Physical exam findings on 9-2-15 included medial right knee tenderness. McMurray's test was positive and range of motion was 0 to 130 degrees. Mild effusion was noted. The treating physician has not documented trials of anti-depressants or anti-convulsants. The treating physician has not documented intolerance to similar medications taken on an oral basis, nor objective evidence of functional improvement from any previous use. The criteria noted above not having been met, Flurbiprofen 20%/Cyclobenzaprine 10%/Menthol Cream 4% 180gm is not medically necessary.

**MRI (Magnetic Resonance Imaging) of the right knee:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Knee Complaints 2004, Section(s): Special Studies.

**MAXIMUS guideline:** Decision based on MTUS Knee Complaints 2004, Section(s): Special Studies.

**Decision rationale:** The requested MRI (Magnetic Resonance Imaging) of the right knee is not medically necessary. American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004), Chapter 13, Knee Complaints, Special Studies and Diagnostic and Treatment Considerations, page 343, note that imaging studies of the knee are recommended with documented exam evidence of ligament instability or internal derangement after failed therapy trials. The injured worker has right knee pain secondary to compensatory factors, left knee meniscal tear, status post left knee arthroscopy, and posttraumatic osteoarthritis of the left knee. Treatment to date has included a home exercise program and medication including Naprosyn. Physical exam findings on 9-2-15 included medial right knee tenderness. McMurray's test was positive and range of motion was 0 to 130 degrees. Mild effusion was noted. The treating physician has not documented recent therapy trials to the right knee. The criteria noted above not having been met, MRI (Magnetic Resonance Imaging) of the right knee is not medically necessary.