

Case Number:	CM15-0087922		
Date Assigned:	05/12/2015	Date of Injury:	07/20/2012
Decision Date:	07/07/2015	UR Denial Date:	04/17/2015
Priority:	Standard	Application Received:	05/07/2015

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: Texas, Florida
 Certification(s)/Specialty: Anesthesiology, 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 52 year old male, who sustained an industrial injury on 7/20/2012. Diagnoses are right hip and bilateral knees pain. Treatment to date has included Supartz injection, medications and modified work. Per the Primary Treating Physician's Progress Report dated 3/11/2015, the injured worker reported worsened bilateral knee pain rated as 7/10. Physical examination revealed progressive pain and swelling of the bilateral knees. The plan of care included an injection and medications and authorization was requested for Orphenadrine/caffeine, Flurbiprofen/Omeprazole and Flurbiprofen/Cyclobenzaprine/menthol cream. The other medications listed include diclofenac sodium ER, pantoprazole sodium ER and diclofenac/lidocaine 3%/5% topical. The 10/29/2014 UDS was reported as consistent with prescribed hydrocodone.

IMR ISSUES, DECISIONS AND RATIONALES

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

Gabapentin/Pyridoxine 250/10mg quantity 120: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 9492.24.2 Page(s): 16-22. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter Anticonvulsants.

Decision rationale: The CA MTUS and the ODG guidelines recommend anticonvulsants can be utilized for the treatment of neuropathic and radicular pain syndrome. The records show that the patient is utilizing formulation of gabapentin with pyridoxine. There is no documentation of vitamin or nutritional deficiency associated with the musculoskeletal pain in this patient. The records did not show that the patient failed treatment with standard formulations of gabapentin. The criteria for the use of gabapentin 250mg / pyridoxine 10mg #120 was not medically necessary.

Keratek gel 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 9792.24.2 Page(s): 111-113. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter Topical Analgesics.

Decision rationale: The CA MTUS and the ODG guidelines recommend that topical products can be utilized for the treatment of localized neuropathic pain when treatment with first line antidepressant and anticonvulsant medications has failed. The records did not show subjective or objective findings of localized neuropathic pain such as CRPS. The recommended second - line medication was single formulation of topical lidocaine. There is no documentation of failure of first line or second medications. The patient is utilizing multiple formulations of topical products concurrently. The Keratek product contains menthol 16% / methyl salicylate 28%. There is lack of guidelines or FDA support for the use of menthol and methyl salicylate in the treatment of chronic musculoskeletal pain. The criteria for the use of Keratek gel 4oz bottle as not medically necessary.

Orphenadrine/Caffeine 50/10mg quantity 60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants for pain.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 9792.24.2 Page(s): 65. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter Muscle Relaxants.

Decision rationale: The CA MTUS and the ODG guidelines recommend that muscle relaxants can be utilized for a short term treatment of exacerbation of musculoskeletal pain. The chronic use of muscle relaxants can be associated with the development of tolerance, dependency, sedation, addiction and adverse interaction with other sedative agents. The records indicate that the duration of utilization of orphenadrine had exceeded the patient had utilized maximum

period of 4 to 6 weeks recommended by the guidelines. There is no documentation that the patient required a special formulation of orphenadrine with caffeine because on non efficacy of standard formulation of orphenadrine. The criteria for the use of orphenadrine / caffeine 50mg /10 mg #60 were not medically necessary.

Flurbiprofen/Omeprazole 100/10mg quantity 60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Non Steroidal Anti Inflammatory Drugs.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 9792.24.2 Page(s): 67-73. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter NSAIDs.

Decision rationale: The CA MTUS and the ODG guidelines recommend that NSAIDs can be utilized for the treatment of exacerbation of musculoskeletal pain. The chronic use of NSAIDs can be associated with the development of renal, cardiac and gastrointestinal complications. The risks of complications increase significantly with utilization of multiple NSAID products. The records indicate that the patient is utilizing multiple formulations of oral and topical NSAIDs. The patient is also utilizing other proton pump inhibitors. There is no documentation of failure of standard single oral NSAID formulation. The criteria for the use of flurbiprofen 100mg / omeprazole 10mg #60 was not medically necessary.

Flurbiprofen 20%/Cyclobenzaprine 10%/Menthol 4% cream quantity 180gm: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Non Steroidal Anti Inflammatory Drugs.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 9792.24.2 Page(s): 111-113. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter Topical Analgesics.

Decision rationale: The CA MTUS and the ODG guidelines recommend that topical products can be utilized for the treatment of localized neuropathic pain when treatment with first line antidepressant and anticonvulsant medications has failed. The records did not show subjective or objective findings of localized neuropathic pain such as CRPS. The recommended second - line medication was single formulation of topical lidocaine. There is no documentation of failure of first line or second medications. The patient is utilizing multiple formulations of NSAIDs and topical product concurrently. The criteria for the use of flurbiprofen 20% / cyclobenzaprine 10% / menthol 4% cream quantity 180gm was not medically necessary.