

<b>Case Number:</b>	CM15-0095701		
<b>Date Assigned:</b>	07/15/2015	<b>Date of Injury:</b>	10/27/2009
<b>Decision Date:</b>	09/01/2015	<b>UR Denial Date:</b>	04/29/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/18/2015

### 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: Illinois, California, Texas  
 Certification(s)/Specialty: Orthopedic Surgery

### CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

This injured worker is a 57-year-old male who sustained an industrial injury on 10/27/09. Injury occurred while carrying a king-sized mattress up a flight of stairs. Past surgical history was positive for anterior posterior spinal fusion at L4-S1 with posterior decompression on 11/18/14. The 8/2/14 right knee MRI impression documented a bucket handle tear of the medial meniscus, full thickness chondral defects at the patellofemoral joint with adjacent bone marrow edema, chondromalacia patella, quadriceps and patellar tendinosis, enthesopathy formation at the patellar attachment of the quadriceps tendon, suprapatellar and tibiofemoral joint effusion, and laxity of the medial collateral ligament. The 3/25/15 treating physician report cited complaints that included headaches, and neck, mid and upper back, lower back, right shoulder, right elbow, right knee, right ankle, and right wrist pain, numbness in the right wrist. In general, pain ranged from grade 2-4/10, with right knee pain reported grade 4/10. He reported that physical therapy helped to decrease his pain and tenderness. He was ambulating with a cane. Physical exam was positive for tenderness to palpation in all areas of complaint, and restricted cervical, lumbar and right shoulder rpm. Straight leg raise was positive bilaterally. Right knee exam documented quadriceps atrophy, 3/5 quadriceps/hamstring weakness, positive McMurray's test, and positive posterior drawer test. Imaging showed a medial meniscus tear, osteochondral lesions, and degenerative joint disease. The injured worker had reportedly failed conservative treatments for the right knee including rest, off work, medications, physical therapy and injections. The treatment plan recommended continued physical therapy for the lumbar spine and right knee (completed 5 visits to date). Authorization was requested for right knee arthroscopic surgery with

partial meniscectomy and chondroplasty, Flurbi (Nap) cream 180g, GabaCycloTram cream 180g, and unknown pre-operative screening. The 4/10/15 spine surgery report cited persistent back pain but a reduction in right leg pain to grade 1-2/10. There was residual extensor hallucis longus weakness improving with therapy. The injured worker was continuing an exercise and walking program. The 4/29/15 utilization review non-certified the requests for Fluri (Nap) and GabaCycloTram creams as the components of these compound creams were not fully guideline supported. The requests for right knee arthroscopic meniscectomy and chondroplasty and associated pre-operative screening were non-certified based on an absence of mechanical symptoms and objective findings consistent with guideline criteria.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

#### **Flurbi (Nap) cream 180g: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Medications, Topical NSAIDs, Lidocaine, topical, Topical Analgesics, Compounded.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical analgesics Page(s): 111-113.

**Decision rationale:** Flurbi (Nap) topical cream contains Flurbiprofen, Lidocaine, and amitriptyline. The California MTUS guidelines for topical analgesics state that any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Guidelines state that topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. Topical agents 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. Flurbiprofen is not on the list of approved topical non-steroidal anti-inflammatory drugs. Topical lidocaine is not recommended for non-neuropathic pain and only Lidocaine in the dermal patch formulation is recommended for neuropathic pain. There is no evidence based medical guidance relative to the safety or efficacy of topical amitriptyline. Given the absence of guideline support for all components of this product, this product is not recommended by guidelines. Therefore, this request is not medically necessary.

#### **GabaCycloTram cream 180g: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Medications, Compounded, Gabapentin, topical, Other muscle relaxants.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical analgesics Page(s): 111-113.

**Decision rationale:** GabaCycloTram topical cream contains gabapentin, cyclobenzaprine, and Tramadol. The California MTUS guidelines for topical analgesics state that any compounded product that contains at least one drug (or drug class) that is not recommended is not

recommended. Guidelines state that topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. Topical agents 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. Topical gabapentin is not recommended by the guidelines. Guidelines state there is no evidence for use of a muscle relaxant, such as cyclobenzaprine, as a topical product. There is no evidence based medical support for the safety or efficacy of Tramadol used topically. Given the absence of guideline support for all components of this product, this product is not recommended by guidelines. Therefore, this request is not medically necessary.

**Right knee arthroscopic surgery with partial meniscectomy and chondroplasty:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 344-345. Decision based on Non-MTUS Citation Official Disability Guidelines, Knee & Leg, Meniscectomy, Chondroplasty.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 343-345. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee and Leg: Meniscectomy; Chondroplasty.

**Decision rationale:** The California MTUS guidelines state that surgical consideration may be indicated for patients who have activity limitation for more than one month and failure of exercise programs to increase range of motion and strength of the musculature around the knee. Guidelines support arthroscopic partial meniscectomy for cases in which there is clear evidence of a meniscus tear including symptoms other than simply pain (locking, popping, giving way, and/or recurrent effusion), clear objective findings, and consistent findings on imaging. The Official Disability Guidelines criteria for meniscectomy include conservative care (exercise/physical therapy and medication or activity modification) plus at least two subjective clinical findings (joint pain, swelling, feeling or giving way, or locking, clicking or popping), plus at least two objective clinical findings (positive McMurray's, joint line tenderness, effusion, limited range of motion, crepitus, or locking, clicking, or popping), plus evidence of a meniscal tear on MRI. Criteria for chondroplasty include evidence of conservative care (medication or physical therapy), plus joint pain and swelling, plus effusion or crepitus or limited range of motion, plus a chondral defect on MRI. Guideline criteria have not been fully met. This injured worker presents with multiple complaints, including right knee pain. Clinical findings are consistent with imaging evidence of a medial meniscus tear. There is also imaging evidence of a full thickness chondral lesion. However, there is no documentation in the clinical records of mechanical symptoms or swelling. Physical therapy was on-going at the time of the surgical request (with benefit and with a progressive exercise and walking program documented.) Detailed evidence of a recent, reasonable and/or comprehensive non-operative treatment protocol trial and failure has not been submitted. Therefore, this request is not medically necessary at this time.

**Unknown pre-operative screening:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.