

Case Number:	CM14-0141348		
Date Assigned:	09/18/2014	Date of Injury:	06/20/2011
Decision Date:	11/13/2014	UR Denial Date:	08/19/2014
Priority:	Standard	Application Received:	09/02/2014

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. The expert reviewer is Board Certified in Physical Medicine and Rehabilitation, has a subspecialty in Neuromuscular Medicine and is licensed to practice in Maryland. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 patient is a 48 year old male with a work injury dated 6/20/11. The diagnoses include elbow lateral epicondylar tear, LS-51 radiculopathy, shoulder impingement syndrome, and left knee pain. Operative report dated 6/10/14 indicated he had an arthrotomy of the right elbow with an anterior transposition of the ulna nerve of the right elbow and ulnar nerve neuroplasty of the right elbow and medial epicondylectomy of the right elbow and a medial release of the right elbow with partial synovectomy, removal of loose bodies with an intraarticular injection. Under consideration are requests for Omeprazole 10mg/Flurbiprofen 100mg, QTY: 60; Flurbiprofen 20%/Cyclo 10%/Menth 4% Crea, QTY: 180grams; Gabapentin 250MG/Pyridoxine 10MG, QTY: 60; Orphenadrine/Caffeine 50/10mg, QTY: 60; and Keratek Gel, QTY: 4oz. A 4/7/14 document states that the patient has right shoulder impingement syndrome and cubital tunnel syndrome of the right elbow with severe subluxation of the ulnar nerve, which is palpable. He underwent left elbow surgery dated 6/10/14 as noted above. Per documentation a PR-2 dated 7/31/14 by noted that the patient was seen for follow up of his right elbow and right shoulder. It was noted the patient had progress to his right elbow since his surgery and physical therapy program. He had some lateral stiffness. X-rays revealed progression of degenerative changes. He was to continue to have physical therapy and was prescribed medications which are under consideration.

IMR ISSUES, DECISIONS AND RATIONALES

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

Omeprazole 10mg/Flurbiprofen 100mg, qty: 60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): 18, 65, 68, 70, 72, 105, 111-113. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment Guidelines, Chronic Pain Treatment Guidelines Flurbiprofen; NSAIDs, GI symptoms & cardiovascular risk Page(s): 72.

Decision rationale: Omeprazole 10mg/Flurbiprofen 100mg, qty: 60 is not medically necessary per the MTUS Chronic Pain Medical Treatment Guidelines. The guidelines state that proton pump inhibitors can be used if the patient is "Determine if the at risk for gastrointestinal events. The risk factors include (1) age > 65 years; (2) history of peptic ulcer, GI bleeding or perforation; (3) concurrent use of ASA, corticosteroids, and/or an anticoagulant; or (4) high dose/multi pie NSAID (e.g., NSAID+ low-dose ASA)." The MTUS guidelines state that Flurbiprofen can be used for osteoarthritis. The MTUS guidelines do not discuss Omeprazole/Flurbiprofen specifically but due to the fact that the patient has no gastrointestinal risk factors Omeprazole is not medically necessary and therefore the combination Omeprazole 10mg/Flurbiprofen 100mg, qty: 60 is not medically necessary.

Flurbiprofen 20%/cyclo 10%/menth 4% cream, qty: 180 grams: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Compounded Topical Analgesic Page(s): 18, 65, 68, 70, 72, 105, 111. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

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

Decision rationale: Flurbiprofen20%/Cyclo10%/Menth4% Cream, QTY: 180 grams is not medically necessary per the MTUS Chronic Pain Medical Treatment Guidelines. The MTUS guidelines do not support the use of topical Cyclobenzaprine. The guidelines do support topical Ben Gay which contains menthol. The guidelines state that topical non-steroidal anti-inflammatory medications may be useful for chronic musculoskeletal pain, but there are no long-term studies of their effectiveness or safety. They are indicated in osteoarthritis and tendinitis, in particular, that of the knee and elbow or other joints that are amenable to topical treatment. Topical non-steroidal anti-inflammatory drugs (NSAIDs) are recommended for short-term use (4-12 weeks). There is little evidence to utilize topical NSAIDs for treatment of osteoarthritis of the spine, hip or shoulder and no evidence for use in neuropathic pain. The guidelines state that any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. The guidelines do not recommend topical Cyclobenzaprine. Also it is not clear which body part the patient will be applying this cream. For these reasons Flurbiprofen20%/Cyclo10%/Menth4% Cream, qty: 180 grams is not medically.

Gabapentin 250mg/pyridoxine 10mg, qty: 60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Compounded Medication Page(s): 18, 65, 68, 70, 72, 105, 111-113. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Gabapentin Page(s): 18-19. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain- Vitamin B

Decision rationale: Gabapentin 250mg/pyridoxine 10mg, qty: 60 is not medically necessary per the MTUS Chronic Pain Medical Treatment Guidelines. The MTUS states that Gabapentin is considered as a first-line treatment for neuropathic pain. The ODG states that Vitamin B is not recommended as there is insufficient evidence for treating peripheral polyneuropathy and the evidence is insufficient to determine whether Vitamin B is beneficial or harmful. The documentation does not indicate that the patient has a nutritional deficiency and the lack of support for pyridoxine make the request for Gabapentin 250mg/pyridoxine 10mg, qty: 60 medically unnecessary.

Orphenadrine/Caffeine 50/10mg, qty: 60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Compounded Muscle Relaxants; NSAIDs Page(s): 18, 65, 68, 70, 72, 1. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antispasmodics Page(s): 63-65.

Decision rationale: Orphenadrine/Caffeine 50/10mg, qty: 60 is not medically necessary per the MTUS Chronic Pain Medical Treatment Guidelines. Orphenadrine is stated by the MTUS to have been reported in case studies to be abused for euphoria and to have mood elevating effects. The MTUS recommends non-sedating muscle relaxant with caution as a second-line option for short-term treatment of acute exacerbations in patients with chronic lower back pain (LBP). The recent documentation does not indicate an acute exacerbation requiring antispasmodics. The patient has chronic pain and this medication has been used much longer than a short term period. The request for Orphenadrine/Caffeine 50/10mg, QTY: 60 is not medically necessary.

Keratek Gel, qty : 4oz: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 18, 65, 68, 70, 72, 105, 111-113. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical salicylates-and topical analgesics Page(s): 105; 111-113.

Decision rationale: Keratek Gel qty 4 oz is not medically necessary per the MTUS Chronic Pain Medical Treatment Guidelines. The guidelines state that topical salicylate (e.g., Ben-Gay, methyl salicylate) are significantly better than placebo in chronic pain. The guidelines also state that there is little to no research to support the use of many of these agents. Keratek Gel contains the active ingredients of Menthol 16% and Methyl Salicylate 28%. The documentation is not clear why the patient cannot use an over the counter methyl salicylate. The documentation indicates no intolerance to oral medications. The request for Keratek Gel qty 4 oz is not medically necessary.