

Case Number:	CM14-0147858		
Date Assigned:	09/15/2014	Date of Injury:	04/26/2011
Decision Date:	10/29/2014	UR Denial Date:	08/22/2014
Priority:	Standard	Application Received:	09/11/2014

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 Anesthesiology, has a subspecialty in Pain Medicine and is licensed to practice in Texas. 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 injured worker is a 27 year-old female who is reported to have a date of injury of 04/25/11. It is reported on the date of injury she bent down to pick up a ladder and sustained a right knee injury. She was treated with oral medications, physical therapy and ultimately surgery on 11/01/11. Postoperatively the injured worker has chronic pain. MRI of the right knee dated 07/03/12 shows no evidence of significant abnormality. The record contains a single clinical note dated 07/30/14 which reports the injured worker has right knee pain. On examination there is tenderness of the right knee. The record contains a utilization review determination dated 08/22/14 in which requests for 1 bottle of Keratek Gel 4 Oz, 40 tablets of Hydrocodone/APAP/Ondan 10/300/2 mg, and a compounded medication which contains Flurbiprofen 20%, Cyclobenzaprine 10%, Menthol 4% 180 grams was non-certified.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 bottle of Keratek gel 4oz: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-114..

Decision rationale: The request for 1 bottle of Keratek gel 4 oz is not supported as medically necessary. The submitted clinical records indicate the injured worker has recurrent right knee pain. The single clinical note does not provide a detailed examination or pertinent clinical data. The California Medical Treatment Utilization Schedule does not support the topical analgesics noting the safety and efficacy of the topical medications has not been established through rigorous clinical trials. As such, the medical necessity has not been established.

40 tablets of Hydrocodone/APAP/Ondan 10-300-2mg: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opiates Page(s): 74-80.

Decision rationale: The request for 40 tablets of Hydrocodone/APAP/Odan 10/300/2mg is not supported as medically necessary. The submitted clinical records indicate the injured worker has suffered an exacerbation of a chronic injury. There is no documentation of an intervening injury. The submitted clinical examination is cursory and does not suggest that the injured worker's pain is such to require opiate medications. Further, there is no indication of a trial of NSAID's prior to the recommendation for opiates. As such the request would not meet the criteria per California Medical Treatment Utilization Schedule.

1 tube of flurbiprofen 20% , Cyclobenzaprine 10%, Menthol 4% cream 180grams: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines - Treatment for workers compensation.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-114. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter, Compounded Medications

Decision rationale: The request for a compounded medication which contains Flurbiprofen 20%, Cyclobenzaprine 10%, Menthol 4% 180 grams is not medically necessary. The California Medical Treatment Utilization Schedule, the Official Disability Guidelines (ODG) and US FDA do not recommend the use of compounded medications as these medications are noted to be largely experimental in use with few randomized controlled trials to determine efficacy or safety. Further, the FDA requires that all components of a transdermal compounded medication be approved for transdermal use. This compound contains: Flurbiprofen 20% and Cyclobenzaprine 10% which have not been approved by the FDA for transdermal use. Any compounded product that contains at least one drug (or drug class) that is not recommended and therefore not medically necessary.