

Case Number:	CM14-0148750		
Date Assigned:	09/18/2014	Date of Injury:	07/21/2009
Decision Date:	05/13/2015	UR Denial Date:	09/05/2014
Priority:	Standard	Application Received:	09/12/2014

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. 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: New York

Certification(s)/Specialty: Anesthesiology

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 58 year old male, who sustained an industrial injury on July 21, 2009. The injured worker was diagnosed as having lumbar sprain/strain, broad based posterior L4-L5 disc protrusion, posterior central L3-L4 disc protrusion, lumbar spine nerve root irritation, osteoarthritis of the lower leg, and lower leg joint pain. Treatment to date has included physical therapy and medication. Currently, the injured worker complains of right knee pain with limited range of motion (ROM), rating his pain level at a 7 on a scale of 1-10, with 10 being the worse. The Primary Treating Physician's report dated August 18, 2014, noted the injured worker was to receive his first out of a series of five Hyalgan injections to the right knee. The injured worker was noted to have mid tenderness, limited range of motion (ROM), and a limping ambulation. The Physician dispensed Hydrocodone/APAP, Diclofenac Sodium, Pantoprazole Sodium ER, with authorization requested for a urine toxicology screening, and given a prescription for Theraflex cream and Keratek gel. The injured worker was advised to return in one week for the second Hyalgan injection.

IMR ISSUES, DECISIONS AND RATIONALES

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

Med x 1: Keratek Analgesic gel x 4 oz.: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints, Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111.

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

Decision rationale: According to the California MTUS Guidelines (2009), topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. These agents are applied topically to painful areas with advantages that include lack of systemic side effects, absence of drug interactions, and no need to titrate. Many agents are compounded as monotherapy or in combination for pain control including, for example, NSAIDs, opioids, capsaicin, muscle relaxants, local anesthetics or antidepressants. Guidelines indicate that any compounded product that contains at least 1 non-recommended drug (or drug class) is not recommended for use. Keratek contains menthol and methyl salicylate. The patient has nociceptive pain rather than neuropathic pain and there is no documentation of inability to use an oral agent. Medical necessity for the requested topical analgesic has not been established. The requested topical gel is not medically necessary.

Med x1: Flurbiprofen/cyclo/ment cream 20%/10%/4% x 120gm: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints, Chronic Pain Treatment Guidelines Topical non-steroidal anti-inflammatory agents Page(s): 111.

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

Decision rationale: According to the California MTUS Guidelines (2009), topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. These agents are applied topically to painful areas with advantages that include lack of systemic side effects, absence of drug interactions, and no need to titrate. Many agents are compounded as monotherapy or in combination for pain control including, for example, NSAIDs, opioids, capsaicin, muscle relaxants, local anesthetics or antidepressants. Guidelines indicate that any compounded product that contains at least 1 non-recommended drug (or drug class) is not recommended for use. The requested topical analgesic compound for this patient contains Flurbiprofen and Cyclobenzaprine. The MTUS guidelines state that Flurbiprofen, and/or muscle relaxants are not recommended for topical applications. Cyclobenzaprine is not FDA approved for use as a topical application. Medical necessity for the requested topical analgesic compounded medication, for muscular pain, has not been established. The requested topical compound is not medically necessary.

Med x 1: Diclofenac Sodium ER 100mg x60 dispensed: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints, Chronic Pain Treatment Guidelines Non-steroidal anti-inflammatory agents Page(s): 71.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): 67-71. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) NSAIDs.

Decision rationale: According to California MTUS Guidelines, oral NSAIDs, such as Diclofenac, are recommended for the treatment of chronic pain and control of inflammation as a second-line therapy after acetaminophen. The ODG states that NSAIDs are recommended for acute pain, acute low back pain (LBP), and short-term pain relief in chronic LBP. There is no evidence of long-term effectiveness for pain or function. According to the ODG, there is inconsistent evidence for the use of NSAIDs to treat long-term neuropathic pain, but they may be useful to treat breakthrough pain in this condition. The medication is not considered by peer-reviewed guidelines as a first-line NSAID. There is no documentation of the frequency with which the medication should be taken. The CA MTUS states that Diclofenac sodium ER should only be used as chronic maintenance therapy and 100mg once a day is considered to be the appropriate dose. The provider has requested 60 tablets presumably for one-month supply and therefore this would not be consistent with the guidelines. Medical necessity for the requested medication has not been established. The requested medication is not medically necessary.

Med x1: Pantoprazole Sodium ER 20mg x 60 dispensed: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints, Chronic Pain Treatment Guidelines Proton-pump inhibitors Page(s): 68.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines PPIs Page(s): 68. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) PPIs.

Decision rationale: According to CA MTUS (2009), proton pump inhibitors (PPIs), such as Pantoprazole (Protonix), are recommended for patients taking NSAIDs with documented GI distress symptoms or specific GI risk factors. There is no documentation indicating the patient has any GI symptoms or GI risk factors. Risk factors include, age > 65, history of peptic ulcer disease, GI bleeding, concurrent use of aspirin, corticosteroids, and/or anticoagulants or high-dose / multiple NSAIDs. There is no documentation of any reported GI complaints. Based on the available information provided for review, the medical necessity for Protonix has not been established. The requested medication is not medically necessary.