

Case Number:	CM15-0168269		
Date Assigned:	09/15/2015	Date of Injury:	09/23/2009
Decision Date:	11/18/2015	UR Denial Date:	07/24/2015
Priority:	Standard	Application Received:	08/26/2015

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: California
 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:

The injured worker is a 50 year old female who sustained an industrial injury September 29, 2009, after falling down stairs with a twisting injury to her left knee. Past history included a right total knee arthroplasty. Past treatment included physical therapy, medication, bracing, and rest. According to an initial orthopedic evaluation report, dated July 1, 2015, the injured worker presented with complaints of left knee pain with grinding. She can only walk for a few blocks before stopping due to pain. Physical examination revealed; walks with left antalgic gait; left knee- moderate intra-articular effusion above the knee; marked pain to palpation over the medial and lateral joint lines; patellar is tracking laterally within the trochlear notch when seated and flexed to 90 degrees; patella apprehension sign is positive; patella grind test positive with severe patella crepitus; range of motion of the knee is full; McMurray's sign is positive; sensation intact. The physician documents that X-rays of the left knee (three views) and tibia (two views) show severe advanced tricompartmental osteoarthritis. Diagnosis is documented as severe tricompartmental osteoarthritis of the left knee. Treatment plan included a request for authorization for left total knee arthroplasty (authorized). At issue, is the request for authorization for a cold therapy unit purchase, continue passive motion x 21 day rental, Flurbiprofen-Cyclo-Menthol cream, Gabapentin-Pyridoxine, Keratek gel, Mometasone-Doxepin, Omeprazole-Flurbiprofen, and Orphenadrine-Caffeine. According to utilization review, dated July 24, 2015, the request for Orphenadrine-Caffeine 50-10mg #60 is non-certified. The request for Gabapentin-Pyridoxine 250-10mg #60 (two times daily) is non-certified. The request for Omeprazole-Flurbiprofen 10-100mg capsules #60 is non-certified. The request for Flurbiprofen-

Cyclo-Menthol 20%- 10%-4% cream 180 for pain is non-certified. The request for Keratek Gel 4oz bottle-pain-inflammation is non-certified. The request for Mometasone-Doxepin 0.15%-5% (apply 1-2 times, 2-3 times per day) is non-certified. The request for a continuous passive motion x 21 days has been modified to continuous passive motion 17 day rental. The request for a cold therapy unit purchase has been modified to a cold therapy unit x 7 day rental.

IMR ISSUES, DECISIONS AND RATIONALES

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

Orphenadrine/Caffeine 50/10mg #60: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Treatment Index, 13th Edition (web), 2015, Pain (Chronic): Compound drugs.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Muscle relaxants (for pain).

Decision rationale: CA MTUS Chronic Pain Medical Treatment Guidelines, pages 64-65 reports that muscle relaxants such as Orphenadrine are recommended to decrease muscle spasm in conditions such as low back pain although it appears that these medications are often used for the treatment of musculoskeletal conditions whether spasm is present or not. The mechanism of action for most of these agents is not known. As the patient has no evidence in the records of significant spasms objectively, the request for Orphenadrine/Caffeine is not medically necessary and appropriate.

Gabapentin/Pyridoxine 250/10mg #60 (2 times daily): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Treatment Index, 13th Edition (web), 2015, Pain (Chronic): Compound drugs.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Antiepilepsy drugs (AEDs).

Decision rationale: Per the CA MTUS Chronic Pain Treatment Guidelines page 18, Specific Anti-Epilepsy Drugs, Neurontin is indicated for diabetic painful neuropathy and post herpetic neuralgia and is considered first line treatment for neuropathic pain. In this case, the exam note from 7/1/15 does not demonstrate evidence neuropathic pain or demonstrate percentage of relief, the duration of relief, increase in function or increased activity. Therefore medical necessity has not been established. The request is not medically necessary and appropriate.

Flurbiprofen/Cyclo/Menthol 20%/10%/4% cream 180- for pain: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Topical Analgesics.

Decision rationale: Per the CA MTUS regarding topical analgesics, Chronic Pain Medical Treatment Guidelines, Topical analgesics, page 111-112 are largely experimental in use with few randomized controlled trials to determine efficacy or safety. 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. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Therefore the request is not medically necessary.

Keratek gel 4oz bottle- pain/inflammation: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Topical Analgesics.

Decision rationale: Per the CA MTUS regarding topical analgesics, Chronic Pain Medical Treatment Guidelines, Topical analgesics, page 111-112 are largely experimental in use with few randomized controlled trials to determine efficacy or safety. 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. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Therefore the request is not medically necessary.

Mometasone/Doxepin 0.15%/ 5% (apply 1-2 times, 2-3 times per day): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Topical Analgesics.

Decision rationale: Per the CA MTUS regarding topical analgesics, Chronic Pain Medical Treatment Guidelines, Topical analgesics, page 111-112 are largely experimental in use with few randomized controlled trials to determine efficacy or safety. 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. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Therefore the request is not medically necessary.

Associated surgical service: Continuous passive motion x 21 day rental: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Treatment Index, 13th Edition (web), 2015, Knee & Leg, Continuous passive motion (CPM).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee and Leg, CPM.

Decision rationale: CA MTUS/ACOEM is silent on the issue of CPM. According to ODG Knee and Leg, CPM is medically necessary postoperatively for 4-10 consecutive days but no more than 21 following total knee arthroplasty. As the guideline criteria have been met, the request is medically necessary.

Associated surgical service: Cold therapy unit purchase: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Treatment Index, 13th Edition (web), 2015, Knee & Leg, Continuous-flow cryotherapy.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee and Leg, Continuous flow cryotherapy.

Decision rationale: CA MTUS/ACOEM is silent on the issue of cryotherapy. According to ODG, Knee and Leg Chapter regarding continuous flow cryotherapy it is a recommended option after surgery but not for nonsurgical treatment. It is recommended for upwards of 7 days postoperatively. In this case the request has an unspecified amount of days. Therefore the request is not medically necessary.

Omeprazole/Flurbiprofen 10/100mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Treatment Index, 13th Edition (web), 2015, Pain (Chronic): Compound drugs.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): NSAIDs, GI symptoms & cardiovascular risk.

Decision rationale: Per the CA MTUS Chronic Pain Medical Treatment Guidelines, page 68, recommendation for Prilosec is for patients with risk factors for gastrointestinal events. The cited records from 7/1/15 do not demonstrate that the patient is at risk for gastrointestinal events. Therefore the requested Omeprazole/Flurbiprofen (Prilosec) is not medically necessary.