

Case Number:	CM15-0077611		
Date Assigned:	04/29/2015	Date of Injury:	03/12/2010
Decision Date:	06/23/2015	UR Denial Date:	04/16/2015
Priority:	Standard	Application Received:	04/23/2015

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: 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 61 year old male, who sustained an industrial injury on 03/12/2010. He reported pain and swelling to the left knee. According to a progress report dated 03/19/2015, the injured worker complained of left leg pain with numbness and no changes in progress since the last office visit. He continued to have pain to the left knee and lumbar spine. Treatment to date has included knee surgery, MRI of the lumbar spine, medications, electrical muscle stimulation, therapeutic exercise and spinal manipulation, x-rays of the left knee and left tibia and physical therapy. Treatment plan included Orphenadrine/Caffeine, Flurbiprofen/Omeprazole, Flurbiprofen/Cyclobenzaprine/Menthol Cream, Gabapentin/Pyridoxine and Kera Tek Gel.

IMR ISSUES, DECISIONS AND RATIONALES

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

Orphenadrine 50/10mg/Caffeine 50/10mg quantity 60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Orphenadrine.

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

Decision rationale: According to the ODG, Orphenadrine (Norflex) is a muscle relaxant similar to diphenhydramine, but has greater anticholinergic effects. The mode of action is not clearly understood. Effects are thought to be secondary to analgesic and anticholinergic properties. According to CA MTUS guidelines, muscle relaxants are not considered any more effective than nonsteroidal anti-inflammatory drugs (NSAIDs) alone, and are not recommended for the long-term use of chronic pain. Based on the currently available information, the medical necessity for Orphenadrine has not been established. The requested medication is not medically necessary.

Flurbiprofen/Omeprazole 100/10mg, quantity unspecified: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines PPIs Page(s): 68.

Decision rationale: Flurbiprofen/Omeprazole is a combination nonsteroidal and anti-inflammatory / proton pump inhibitor. The ODG states that NSAIDs are recommended for acute pain, osteoarthritis and acute exacerbations of chronic pain. There is no evidence of long-term effectiveness for pain or function. There is inconsistent evidence for the use of NSAIDs to treat long-term neuropathic pain. Guidelines recommended that the lowest effective dose be used for the shortest duration of time consistent with treatment goals. In this case, the patient has been on previous long-term NSAIDs without any documentation of significant improvement. According to the CA MTUS, proton pump inhibitors, such as Omeprazole (Prilosec), are recommended for patients taking NSAIDs with documented GI distress symptoms or specific 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 indicating the patient has any GI symptoms or GI risk factors. Medical necessity for the requested combination medication has not been established. The requested medication is not medically necessary.

Flurbiprofen/Cyclobenzaprine/Menthol Cream 20%/10%/4%, quantity unspecified:
Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics.

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. In this case, the MTUS guidelines state that Flurbiprofen, and/or muscle relaxants are not recommended for topical applications. In addition, Cyclobenzaprine is not FDA approved for use as a topical application. Medical necessity for the

requested compound topical analgesic has not been established. The requested topical cream is not medically necessary.

Gabapentin/Pyridoxine 250mg/10mg quantity unspecified: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Gabapentin.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Gabapentin (Neurontin) Page(s): 17-19, 49. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Gabapentin.

Decision rationale: Gabapentin (Neurontin) is an anti-epilepsy drug which has been shown to be effective for the treatment of painful diabetic neuropathy and post-herpetic neuralgia, and has been considered as a first-line treatment for neuropathic pain. In this case, there was no documentation of neuropathic pain. Therefore, medical necessity for Gabapentin/Pyridoxine has not been established. In addition, there is no quantity or duration specified. The requested medication is not medically necessary.

Kera Tek Gel quantity 113: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics.

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. In this case, there is no known efficacy of the usage of menthol as a topical analgesic. In addition, there is no documentation of inability to use an oral agent. Medical necessity for the requested topical medication has not been established. The requested topical gel is not medically necessary.