

Case Number:	CM13-0002074		
Date Assigned:	11/08/2013	Date of Injury:	11/15/2005
Decision Date:	08/06/2014	UR Denial Date:	07/12/2013
Priority:	Standard	Application Received:	07/19/2013

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 and is licensed to practice in California. 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 56 year old male who was injured on 11/15/2005. The mechanism of injury is unknown. The patient underwent right knee anterior cruciate ligament reconstruction surgery, date unknown. Prior medication history included Opana 20 mg, Percocet, synovacine, laxazine, MiraLax, and Fortesta. Progress report dated 07/18/2013 documented the patient to have complaints of right knee pain, increasing pain in his low back, left knee pain due to overuse and right shoulder pain. He rated his pain as 7/10 with medication and 9/10 without medications. He does report increased functional improvement and improvement with pain on his medication regimen. On exam, he utilized a walking cane for ambulation. He had tenderness to palpation of his right shoulder over the anterior and lateral aspects. Range of motion is restricted by pain. On examination of the low back, there is tenderness and moderate muscle spasm. The lumbar spine range of motion revealed flexion is 80 degrees; extension to 10 degrees; right lateral flexion to 20 degrees; and left lateral flexion to 20 degrees. The right knee has tenderness as well. He has a diagnosis of left knee pain secondary to right knee injury, hypogonadism secondary to chronic opioid usage, left foot open wound secondary to antalgic gait, opioid-induced constipation, and aggravation of pre-existing symptomatic lumbar condition from gait changes secondary to right knee condition. The treatment plan included Opana ER 20 mg, Percocet 10/325, Laxacin, MiraLax, Synovacin, and [REDACTED] program. There is a request for a trial on ketoprofen/Gabapentin/Lidocaine compound for symptomatic relief of right knee pain. Prior utilization review dated 09/03/2011 states the request for prescription of Opana ER 10mg is not certified as there is a lack of documented functional improvement; retrospective request for range of motion testing is denied as range of motion and manual muscle testing are expected to be a part of the exam and not separately reimbursable; prescription for

ketoprofen/gabapentin/lidocaine creams not certified as MTUS guidelines do not support topical ketoprofen and Gabapentin.

IMR ISSUES, DECISIONS AND RATIONALES

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

PRESCRIPTION OF OPANA ER 10MG: 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 Opioids Dosing Page(s): 86-87. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG) PAIN, OPIOIDS.

Decision rationale: Opana ER is a highly potent opiate indicated for patients who require around the clock pain management. Guidelines indicate "four domains have been proposed as most relevant for ongoing monitoring of chronic pain patients on opioids; pain relief, side effects, physical and psychosocial functioning, and the occurrence of any potentially aberrant (or nonadherent) drug-related behaviors. These domains have been summarized as the "4 A's" (analgesia, activities of daily living, adverse side effects, and aberrant drug-taking behaviors)." In this case, records review indicates that this patient has chronic pain in the lower back, knee and shoulder. However, there is no evidence of any significant reduction in pain level or improvement in function. The guidelines state opiates should continue if patient has improved functioning and pain, which has not been demonstrated in this case. Therefore, the medical necessity of Opana ER is not established at this time.

RETROSPECTIVE REQUEST FOR RANGE OF MOTION TESTING: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG) LOW BACK CHAPTER, RANGER OF MOTION TESTING (FLEXIBILITY).

Decision rationale: Per guidelines, range of motion (and muscle) testing is an integral part of any physical / occupational therapy. In this case, there is no documentation as to why the patient needs ROM testing and what body part is to be tested. Therefore, the medical necessity of the request for ROM cannot be established.

PRESCRIPTION FOR KETOPROFEN/GABAPENTIN/LIDOCAINE CREAM: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TOPICAL ANALGESICS. Decision based on Non-MTUS Citation TOPICAL ANALGESICS.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TOPICAL ANALGESICS Page(s): 111-112. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG0 PAIN CHAPTER, TOPICAL ANALGESICS).

Decision rationale: According to the CA MTUS Guidelines, topical analgesics are an option with specific indications, many agents are compounded as monotherapy or in combination for pain control. 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. According to the guidelines, Gabapentin and Ketoprofen are not recommended for topical application. There is no peer-reviewed literature to support their use. Therefore, the request is not medically necessary according to the guidelines.