

Case Number:	CM13-0040847		
Date Assigned:	12/20/2013	Date of Injury:	04/17/2002
Decision Date:	02/20/2014	UR Denial Date:	10/16/2013
Priority:	Standard	Application Received:	10/29/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Physical Medicine & Rehabilitation and Pain Medicine, and is licensed to practice in Oklahoma and 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 physician 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 62-year-old male who reported an injury on 04/17/2002 due to cumulative trauma. The patient underwent an MRI that revealed a complex tear of the medial meniscus. The patient's most recent clinical examination findings did note that the patient had complaints of mechanical symptoms and a burning sensation in the left knee. Objective findings included restricted range of motion at 128 degrees in flexion of the right knee and 135 degrees in flexion of the left knee and a negative McMurray's test bilaterally. The patient's diagnoses included discogenic disease of the low back with left sciatica, bilateral discoid meniscus of the knees, left with tear of the body of the medial meniscus. The patient's treatment plan included medications.

IMR ISSUES, DECISIONS AND RATIONALES

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

Dendracin lotion #120 (10/13/2009): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation The Claims Administrator based its decision on CA MTUS, ODG Pain, MD Consult Drug Monograph

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

Decision rationale: The requested Dendracin lotion #120 for 10/13/2009 is not medically necessary or appropriate. The requested medication is a compounded topical agent that contains methyl salicylate 30%, capsaicin 0.037%, and menthol 10%. California Medical Treatment Utilization Schedule only recommends capsaicin to be used as a topical analgesic for patients who are intolerant or have not responded to other treatments. Additionally, the formulation of 0.0375% is not recommended over 0.025% as there is no scientific evidence to support the efficacy of the increased percentage of medication. The clinical documentation submitted for review did not include any information from 10/13/2009 to support the need for medication management. Additionally, there is no documentation that the patient has not been responsive or intolerant to other treatments. As such, the requested decision for Dendracin lotion #120 for date of service 10/13/2009 is not medically necessary or appropriate.

Melasom 1.5mg/25mg capsule x30 (5/19/2009 - 10/13/2009): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Pain, MD Consult Drug Monograph

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

Decision rationale: The requested Melasom 1.5 mg/25 mg capsule x30 from 05/19/2009 to 10/13/2009 is not medically necessary or appropriate. This is a compounded medication that contains melatonin and diphenhydramine. Official Disability Guidelines do state that melatonin and sedating antihistamines such as diphenhydramine are used in the treatment of insomnia related to chronic pain. However, there was no clinical documentation submitted for review for the date of service of 05/19/2009 to 10/13/2009 to support the need for medication management of insomnia. As such, the requested Melasom 1.5 mg/25 mg capsule x30 for date of service 05/19/2009 to 10/13/2009 is not medically necessary or appropriate

Glucosamine/Chondroitin cap x 120 (dos 10/13/2009): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Pain, MD Consult Drug Monograph

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Glucosamine (and Chondroitin Sulfate) Page(s): 50.

Decision rationale: The requested glucosamine/chondroitin capsules 120 for date of service 10/13/2009 are not medically necessary or appropriate. California Medical Treatment Utilization Schedule does support the use of this medication for patients with moderate arthritic pain. The clinical documentation did not include an evaluation from 10/13/2009 to support the need for medication management. There is no documentation from the date of service to support that the patient has arthritic pain that would benefit from this type of medication. As such, the requested glucosamine/chondroitin capsules x120 (dos 10/13/2009) are not medically necessary or appropriate.

Boclosodol 5mg/300mg cap x90 (dos 2/13/2009 - 5/19/2009): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Pain, MD Consult Drug Monograph

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Initiating therapy, and Muscle relaxants (for pain) Page(s): 77 and 64.

Decision rationale: The requested Boclosodol 5 mg/300 mg caplets x90 (dos 02/13/2009 - 05/19/2009) are not medically necessary or appropriate. The requested medication is a compounded medication that contains lactose, baclofen, and carisoprodol. California Medical Treatment Utilization Schedule recommends prophylactic treatment for constipation for patients who are on opioid therapy. There was no clinical documentation to support that the patient was taking opioids for the requested date of services from 02/13/2009 to 05/19/2009. Therefore, this medication would not be indicated. California Medical Treatment Utilization Schedule recommends the short-term use of muscle relaxants. California Medical Treatment Utilization Schedule recommends a duration of treatment not to exceed approximately 2 weeks. The request as it is written exceeds this recommendation. Additionally, there is no documentation from the requested dates of service to support the need for medication management. California Medical Treatment Utilization Schedule does not recommend the use of carisoprodol due the high risk of psychological and physical dependence. Additionally, there was no documentation submitted for review between 02/13/2009 and 05/19/2009 to support the need for medication management. Therefore, the necessity of these medications cannot be determined. As such, the requested Boclosodol 5 mg/300 mg cap x90 (dos 02/13/2009 - 05/19/2009) is not medically necessary or appropriate.

Propoxy-N/APA 100-650 tab x60 (dos 2/13/2009 - 5/19/2009): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Pain, MD Consult Drug Monograph

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

Decision rationale: The requested Propoxy-N/APA 100-650 tab x60 (dos 02/13/2009-05/19/2009) is not medically necessary or appropriate. The clinical documentation submitted for review did not include any assessments from the requested date of services. California Medical Treatment Utilization Schedule does not recommend the use of opioids for chronic pain as an initial therapy. There is no way to determine the patient's response to prior medication management. Therefore, opioid usage would not be indicated. As such, the requested Propoxy-N/APA 100-650 tab x60 (dos 02/13/2009-05/19/2009) is not medically necessary or appropriate.

Ambimel 10mg/1.5mg capsule x30 (dos 2/13/2009): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Pain, MD Consult Drug Monograph.

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

Decision rationale: The requested Ambimel 10 mg/1.5 mg capsule x30 (dos 02/13/2009) is not medically necessary or appropriate. The requested medication is a compounded medication that contains zolpidem. Official Disability Guidelines do not recommend the long-term use of zolpidem for treatment of insomnia related to chronic pain. There was no clinical documentation submitted for review from the date of service 02/13/2009 to support sleep deficits that would require medication management. As such, the requested medication Ambimel 10 mg/1.5 mg capsule x30 (dos 02/13/2009) is not medically necessary or appropriate.