

Case Number:	CM13-0049513		
Date Assigned:	12/27/2013	Date of Injury:	08/27/2002
Decision Date:	05/15/2014	UR Denial Date:	10/28/2013
Priority:	Standard	Application Received:	11/08/2013

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 Orthopedic Surgery, and is licensed to practice in Texas and Indiana. 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 65-year-old female who reported an injury on 08/27/2002. The mechanism of injury was not provided for review. The patient sustained an injury to the right knee that ultimately resulted in surgical intervention and postoperative physical therapy. However, pain of the right knee persisted. The patient experienced a fall in 10/2007 due to instability of the right knee, which reportedly caused injury to the left knee. This ultimately resulted in knee surgery in 2010. An MRI of the left knee in 09/2012 revealed a multi-directional degenerative tear of the medial meniscus and lateral meniscus, with evidence of tricompartmental osteoarthritis and prominence of medial plica that may cause impingement. The patient was treated post surgically with a custom made knee brace, a series of Synvisc injections, and multiple medications. The patient's most recent objective clinical findings of the bilateral knees included restricted range of motion in flexion of the left knee at 90 degrees, and 150 degrees of the right knee. The patient's diagnoses included internal derangement of the right knee, internal derangement of the left knee, and depression and stress related to chronic pain. The patient's treatment plan included continued medications and surgical intervention for the left knee.

IMR ISSUES, DECISIONS AND RATIONALES

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

ONE PRESCRIPTION OF VICODIN 7.5/300MG #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Criteria for use. .

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Initiating Therapy Page(s): 77.

Decision rationale: The requested Vicodin 7.5/300 mg #90 is not medically necessary or appropriate. The clinical documentation submitted for review does provide evidence that the patient has chronic left knee pain that would benefit from medication management. The California Medical Treatment Utilization Schedule recommends that the initiation of an opioid should be supported by a pain contract, documentation of specific goals to determine efficacy, and a urine drug screen to assess the patient's compliance to medication usage. The clinical documentation submitted for review does not provide any evidence that the patient has been screened for aberrant behavior, or entered into a pain contract with the treating physician. It is noted that the patient is already on an opioid through another payment source. Although Vicodin may be needed for breakthrough pain, the initiation of this medication is not supported. As such, the requested Vicodin 7.5/300 mg #90 is not medically necessary or appropriate.

ONE PRESCRIPTION OF VOLTAREN 100MG #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Medications for Chronic Pain and NSAIDs (non-steroidal anti-inflam.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Medications for Chronic Pain and NSAIDs (non-steroidal anti-inflammatory drugs) Page(s): 60,67.

Decision rationale: The requested Voltaren 100mg #60 is not medically necessary or appropriate. California Medical Treatment Utilization Schedule recommends the continued use of medications in the management of a patient's chronic pain be supported by documentation of functional benefit and a quantitative assessment of symptom response. The clinical documentation submitted for review does not provide any evidence that the patient receives functional benefit from medication usage. Additionally, there is no documentation that the patient has pain relief as a result of medication usage. Therefore, continued use cannot be supported by the documentation. As such, the requested Voltaren 100 mg #60 is not medically necessary or appropriate.

ONE PRESCRIPTION OF PROTONIX 20MG QTY 60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk Page(s): 68.

Decision rationale: The requested Protonix 20 mg #60 is not medically necessary or appropriate. California Medical Treatment Utilization Schedule does recommend the use of a gastrointestinal protectant when the patient is at risk for developing gastrointestinal disturbances

related to medication usage. The clinical documentation submitted for review does not provide an adequate assessment of the patient's gastrointestinal system to support that the patient is at risk for developing gastrointestinal disturbances related to medication usage. Therefore, continued use would not be supported. As such, the requested prescription for Protonix 20 mg #60 is not medically necessary or appropriate.

ONE PRESCRIPTION OF TEROGIN PATCHES QTY 20: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical lidocaine, capsaicin, salicylate and menthol. .

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

Decision rationale: The requested Terocin patches #20 is not medically necessary or appropriate. California Medical Treatment Utilization Schedule does not recommend the use of topical analgesics as there is a lack of scientific evidence to support safety and efficacy. The requested medication contains topical analgesics to include methyl salicylate, capsaicin, menthol, and lidocaine. California Medical Treatment Utilization Schedule does recommend the use of methyl salicylate, menthol, and lidocaine in a patch form for neuropathic pain. California Medical Treatment Utilization Schedule does support the use of capsaicin as a topical agent when there is evidence that the patient has failed to respond to other treatment modalities. The clinical documentation does indicate that the patient has chronic pain that would support the use of capsaicin as a topical agent. However, California Medical Treatment Utilization Schedule states the continued use of lidocaine in a patch formulation must be supported by documentation of functional benefit and a quantitative assessment of pain relief. The clinical documentation submitted for review does not provide any evidence of functional benefit or a quantitative assessment of pain relief. Therefore, continued use of this medication cannot be supported. As such, the requested Terocin patches #20 is not medically necessary or appropriate.

ONE PRESCRIPTION OF LIDOPRO CREAM: Upheld

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

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

Decision rationale: Knee Complaints Chapter (Acoem Practice Guidelines, 2nd Edition (2004), Chapter 13) Pg The requested prescription for LidoPro cream is not medically necessary or appropriate. The requested medication contains capsaicin, lidocaine, and methyl salicylate in a cream formulation. California Medical Treatment Utilization Schedule does recommend the use of methyl salicylate and menthol for the pain relief of osteoarthritic-related pain. The clinical documentation submitted for review does provide evidence that the patient has osteoarthritic pain. California Medical Treatment Utilization Schedule does recommend the use of capsaicin when the patient has failed to respond to other types of treatment. The clinical documentation

submitted for review does provide evidence that the patient has failed to respond to other types of treatment. However, California Medical Treatment Utilization Schedule does not recommend the use of lidocaine in a cream formulation as it is not FDA-approved to treat neuropathic pain. California Medical Treatment Utilization Schedule states that any compounded topical agent that contains at least 1 drug (or drug class) that is not recommended by guideline recommendations is not supported. As such, the requested LidoPro cream is not medically necessary or appropriate.