

<b>Case Number:</b>	CM13-0052891		
<b>Date Assigned:</b>	04/25/2014	<b>Date of Injury:</b>	08/03/2001
<b>Decision Date:</b>	06/11/2014	<b>UR Denial Date:</b>	10/25/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/18/2013

### 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 & Rehabilitation, has a subspecialty in Sports Medicine and is licensed to practice in 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 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 injured worker is a 53 year old male with a reported injury date on 08/03/2001; the mechanism of injury was not provided. The progress report dated 10/08/2013 noted that the injured worker had complaints that included increased pain to the hip. Objective findings included tenderness to the paravertebral muscles of the lumbar spine with spasms, tenderness to the bilateral MCLs, and tenderness to bilateral joint lines of the knees. Additional findings included positive straight leg raises bilaterally and normal deep tendon reflexes. The request for authorization for a refill of Medrox, Ketoprofen, and Cidaflex was submitted on 10/08/2013. The request for authorization for a TENS unit was also submitted on 10/08/2013.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**TENS UNIT:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous Electrotherapy, Page(s): 114.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous Electrotherapy, Page(s): 114-116.

**Decision rationale:** The request for TENS unit is non-certified. It was noted that the injured worker had complaints that included increased pain to the hip. Objective findings included

tenderness to the paravertebral muscles of the lumbar spine with spasms, tenderness to bilateral MCLs, and tenderness to bilateral joint lines of the knees. Additional findings included positive straight leg raises bilaterally and normal deep tendon reflexes. The California MTUS guidelines do not recommended transcutaneous electrical nerve stimulation as a primary treatment modality, but a one-month home-based TENS trial may be considered as a noninvasive conservative option, if used as an adjunct to a program of evidence-based functional restoration if particular criteria are meet. The guidelines recommend injured workers should have documentation of pain for at least three months, evidence that other pain modalities have been tried and failed, a treatment plan including specific short and long term goals of treatment must be submitted. The medical necessity for the need of TENS unit has not been established. There is inadequate evidence that the injured worker had failed other conservative care treatments and there was no treatment plan provided within the documentation. Additionally, there is a lack of documentation provided that showed the injured worker would use the unit as an adjunct to a functional restoration program. There was a lack of documentation indicating the injured worker underwent a one month trial of TENS as well as the efficacy of the trial. As such this request for TENS unit is not medically necessary.

**MEDROX OINTMENT:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Topical Analgesics.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics, Page(s): 111-113.

**Decision rationale:** The request for medrox ointment is non-certified. It was noted that the injured worker had complaints that included increased pain to the hip. Objective findings included tenderness to the paravertebral muscles of the lumbar spine with spasms, tenderness to bilateral MCLs, and tenderness to bilateral joint lines of the knees. Additional findings included positive straight leg raises bilaterally and normal deep tendon reflexes. The California MTUS guidelines recommend the use of topical non-steroidal anti-inflammatory agents for osteoarthritis, particularly in the knee and elbow joints. Capsaicin is also recommended only as an option in patients who have not responded or are intolerant to other treatments; however there are no studies to support the use of a 0.0375% formulation of capsaicin. The guidelines also state that if a compounded product contains at least one drug that is not recommend than the entire product is not recommended. Medrox ointment is a compounded product that contains capsaicin in the non-recommended 0.0375% formulation. Additionally, it remains unclear as to what the planned therapeutic goals are of this requested medication. It did not appear the injured worker had a diagnosis which was congruent with the recommended usages. As such this request for Medrox ointment is not medically necessary.

**KETOPROFEN 75 MG #60:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS Page(s): 67-68.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Nsaids (Non-Steroidal Anti-Inflammatory Drugs), Page(s): 67-73.

**Decision rationale:** The request for Ketoprofen 75mg #60 is non-certified. It was noted that the injured worker had complaints that included increased pain to the hip. Objective findings included tenderness to the paravertebral muscles of the lumbar spine with spasms, tenderness to bilateral MCLs, and tenderness to bilateral joint lines of the knees. Additional findings included positive straight leg raises bilaterally and normal deep tendon reflexes. The California MTUS guidelines recommend the use of non-steroidal anti-inflammatory drugs for the treatment of osteoarthritis and back pain. It is recommended that the medication should be used at the lowest dose for the shortest period of time for moderate to severe pain. There is no evidence of long-term effectiveness for pain or function. It was noted within the documentation that the injured worker has been prescribed this medication for an unknown duration of time. There was a lack of documentation indicating the efficacy of the medication. As such this request for Ketoprofen 75MG #60 is not medically necessary.

**CIDAFLEX #180:** Upheld

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

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

**Decision rationale:** The request for Cidaflex #180 is non-certified. It was noted that the injured worker had complaints that included increased pain to the hip. Objective findings included tenderness to the paravertebral muscles of the lumbar spine with spasms, tenderness to bilateral MCLs, and tenderness to bilateral joint lines of the knees. Additional findings included positive straight leg raises bilaterally and normal deep tendon reflexes. The California MTUS guidelines recommend glucosamine as an option given its low risk, in injured workers with moderate arthritis pain, especially for knee osteoarthritis. The medical necessity of this request had not been established. The documentation provided did not show significant evidence that the injured worker had a diagnoses of osteoarthritis of the knee. The dosage of the medication was not indicated within the submitted request. As such this request for Cidaflex #180 is not medically necessary.