

Case Number:	CM13-0055044		
Date Assigned:	12/30/2013	Date of Injury:	09/20/2004
Decision Date:	03/31/2014	UR Denial Date:	11/19/2013
Priority:	Standard	Application Received:	11/20/2013

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 Internal Medicine, has a subspecialty in Pulmonary Diseases 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 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 45-year-old male who reported an injury on 09/20/2004, due to a fall that reportedly caused injury to the patient's bilateral knees, right ankle, right wrist, and low back. The patient's treatment history included lumbar epidural steroid injections, physical therapy, knee immobilization, multiple knee surgeries, medications for chronic pain, and injection therapy. The patient was regularly monitored for prescription compliance with urine drug screens. The patient's medication schedule included OxyContin, Norco, Ultram, cyclobenzaprine, Zanaflex, Remeron, and Prilosec. The patient's most recent clinical findings included tenderness to palpation along the lumbar paraspinal musculature, decreased range of motion, and a positive bilateral straight leg raising test. Examination of the right knee revealed mild soft tissue swelling and tenderness to palpation along the medial and lateral joint lines with decreased range of motion secondary to pain. Examination of the left knee revealed medial joint line tenderness. An examination of the right ankle revealed minimal tenderness to palpation along the ankle joint line. The patient's diagnoses included lumbar myoligamentous injury, bilateral knee internal derangement, bilateral ankle internal derangement, possible chronic regional pain syndrome of the lower extremities, psoriatic arthritis, and medication-induced gastritis. The patient's treatment plan included continuation of medications, continuation of physical therapy, and admission into an inpatient detoxification program.

IMR ISSUES, DECISIONS AND RATIONALES

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

Dendracin cream 120 ml: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111-113. Decision based on Non-MTUS Citation FDA (Topical Medication Safety Warning)

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

Decision rationale: The requested compounded medication contains methyl salicylate, menthol, and capsaicin. The Chronic Pain Guidelines support the use of methyl salicylate and menthol for patients with osteoarthritic pain. However, the use of capsaicin as a topical analgesic should be limited to patients who have failed all other first-line options. The clinical documentation submitted for review does not provide any evidence that the patient's pain has failed to respond to first-line treatments to include anticonvulsants and antidepressants; therefore, the use of capsaicin as a topical analgesic would not be supported by guideline recommendations. The guidelines also indicate that any compounded medication that contains at least one (1) drug or drug class that is not submitted by guideline recommendations is not recommended. As such, the requested Dendracin cream 120 ml is not medically necessary or appropriate.

Synovacin 500mg #90: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Medications for Chronic Pain and Glucosamine (and Chondroitin Sulfate) Page(s): 60 and 50.

Decision rationale: The requested medication contains glucosamine, which is supported by Chronic Pain Guidelines in the use of osteoarthritic pain. However, the guidelines indicate that any medication used in the management of a patient's chronic pain, should be supported by documentation of functional benefit and evidence of pain relief. The clinical documentation submitted for review indicates that the patient has worsening pain that is not well-controlled. Therefore, continued use of this medication would not be supported. As such, the requested Synovacin 500 mg #90 is not medically necessary or appropriate.

Prilosec 20mg: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 68. Decision based on Non-MTUS Citation ODG (Pain Chapter), and the FDA (Omeprazole)

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

Decision rationale: The Chronic Pain Guidelines recommend the use of gastrointestinal (GI) protectants for patients who are at risk for developing gastrointestinal disturbances related to

medication usage. The clinical documentation submitted for review indicates that the patient experienced acute gastritis secondary to medication usage and that the use of this medication assists in control of symptoms related to medication-induced gastritis. However, the request is vague and does not clearly identify a recommended duration of treatment or a frequency of medication usage. Therefore, the medical necessity and efficacy and appropriateness of this medication cannot be determined. As such, the requested Prilosec 20 mg is not medically necessary or appropriate.

Fexmid 7.5mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 63.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants Page(s): 63.

Decision rationale: The Chronic Pain Guidelines do not recommend the extended use of muscle relaxants in the management of chronic pain. The guidelines recommend short durations of treatment for this type of medication. The clinical documentation submitted for review does provide evidence that the patient has been on this medication for an extended duration of time. Therefore, continued use would not be supported. As such, the requested Fexmid 7.5 mg #60 is not medically necessary or appropriate.

Ambien 12.5mg #30: 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), Pain Chapter, Insomnia Treatment

Decision rationale: The Official Disability Guidelines recommend this medication for short-term use to assist with establishment of proper sleep hygiene. However, the clinical documentation submitted for review indicates that the patient is already taking Remeron to assist with better sleep quality. The clinical documentation does not support that his medication has not been effectively assisting the patient with sleep quality. Therefore, the addition of Ambien cannot clearly be determined. Clinical documentation indicates that the patient takes 10 mg of this medication every night. The increase in dosage is not supported by the submitted documentation. As such, the requested Ambien 12.5m g #30 is not medically necessary or appropriate.