

Case Number:	CM13-0062212		
Date Assigned:	12/30/2013	Date of Injury:	07/03/2003
Decision Date:	06/12/2014	UR Denial Date:	11/27/2013
Priority:	Standard	Application Received:	12/06/2013

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 California, Oklahoma, Texas and Tennessee. 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 55 year old female who sustained an injury on 07/03/03 while working as a housekeeper. The injured worker was cleaning a restroom and slipped and fell landing in the kneeling position injuring both knees. The injured worker has undergone multiple arthroscopic procedures for both the left and right knee followed by physical therapy. The injured worker has also received multiple Corticosteroid injections to date without substantial relief. The injured worker describes moderate pain in the bilateral knees that is worsened with activities. The injured worker did utilize a cane for long distance walking and for stabilization. The injured worker was also being followed for complaints in the low back. Previous medications have included Tramadol, Terocin cream, and Medrox patches. MRI studies of the knee dated 08/29/13 noted meniscal tearing in the medial meniscus with a diminutive lateral meniscus possibly secondary to postoperative change. No ligamentous tearing was identified. There was spurring within the lateral tibial femoral compartment with noted chondral thinning. In the patella femoral compartment there was a lateral patellar tilt and subluxation without focal chondral defect. A moderate amount of joint effusion was identified. The 2nd MRI from the same date for a different knee noted femoral tibial spurring with again a lateral patellar tilt and subluxation without a focal chondral defect. The clinical report on 10/11/13 indicated the injured worker had been followed for persistent complaints of pain in the low back as well as the bilateral knees. The injured worker's physical examination did note an antalgic gait with tenderness to palpation in the lumbar spine. There was diminished sensation in a left L4 through S1 dermatome. Mild weakness was noted at the left tibialis anterior and extensor hallucis longus. Additional chiropractic therapy was recommended at this visit. The injured worker was continued on Tramadol, Omeprazole, and topical medications. Follow up on 12/05/13 indicated the injured worker had persistent bilateral knee pain rating 8-9/10 on the VAS. The injured

worker indicated her left knee pain has increased and there were popping noises heard. The injured worker did note some decrease in pain with medications. On physical examination, there was a continued mild antalgic gait. Range of motion of the bilateral knees was to 120 degrees flexion. Crepitus was noted with range of motion. No instability was identified. No evidence of swelling or effusion was present in either knee. There was some mild weakness of the quadriceps. The injured worker was recommended for Synvisc injections for the bilateral knees, a series of 3. The injured worker was recommended to continue with a home exercise program as well as continue with Norco 5/325mg as directed. However, it is noted in the note that hydrocodone was discontinued due to an allergic reaction. Additional medications included Tramadol 50mg 2-4 tablets QD, Prilosec 20mg QD, The request for Lidopro topical ointment 4 oz, Teroicin pain patch box (10 patches), omeprazole 20mg capsules, Tramadol ER 150mg capsule, and additional chiropractic treatments for eight (8) visits, lumbar spine, were non-certified on 11/27/13.

IMR ISSUES, DECISIONS AND RATIONALES

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

LIDOPRO TOPICAL OINTMENT 4 OZ.: Upheld

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

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

Decision rationale: As noted on page 111 of the Chronic Pain Medical Treatment Guidelines, the safety and efficacy of compounded medications has not been established through rigorous clinical trials. Lidoderm is recommended for a trial if there is evidence of localized pain that is consistent with a neuropathic etiology. There should be evidence of a trial of first-line neuropathy medications (tri-cyclic or SNRI anti-depressants or an AED such as gabapentin or Lyrica). Lidoderm is not generally recommended for treatment of osteoarthritis or treatment of myofascial pain/trigger points. Therefore, based on guidelines, the request for Lidopro Topical Ointment 4 OZ is not medically necessary.

TEROCIN PAIN PATCH BOX (10 PATCHES): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TOPICAL ANALGESICS Page(s): 105, 112-113.

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

Decision rationale: As noted on page 111 of the Chronic Pain Medical Treatment Guidelines, the safety and efficacy of compounded medications has not been established through rigorous clinical trials. Topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. There is no indication in the documentation that

these types of medications have been trialed and/or failed. Further, CAMTUS, Food and Drug Administration, and Official Disability Guidelines require that all components of a compounded topical medication be approved for transdermal use. Therefore, based on guidelines, the Terocin Pain Patch Box (10 Patches) is not medically necessary.

OMEPRAZOLE 20 MG CAPSULES: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms and Cardiovascular Risk Page(s): 68-69.

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, Proton Pump Inhibitor.

Decision rationale: As noted in the Official Disability Guidelines - Online version, Pain Chapter, proton pump inhibitors are indicated for patients at intermediate and high risk for gastrointestinal events with concurrent use of non-steroidal anti-inflammatory drug use. Risk factors for gastrointestinal events include age > 65 years; history of peptic ulcer, GI bleeding or perforation; concurrent use of ASA, corticosteroids, and/or an anticoagulant; or high dose/multiple NSAID (e.g., NSAID + low-dose ASA). There is no indication that the patient is at risk for gastrointestinal events requiring the use of proton pump inhibitors. Furthermore, long-term PPI use (> 1 year) has been shown to increase the risk of hip fracture. As such, the request for Omeprazole 20 mg Capsules is not medically necessary.

ADDITIONAL CHIROPRACTIC TREATMENTS FOR EIGHT (8) VISITS, LUMBAR SPINE: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy & Manipulation Page(s): 58-60.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines MANUAL THERAPY & MANIPULATION Page(s): 59.

Decision rationale: As noted on page 59 of the Chronic Pain Medical Treatment Guidelines, current guidelines indicate chiropractic frequency of 1 to 2 times per week the first 2 weeks, as indicated by the severity of the condition. Treatment may continue at 1 treatment per week for the next 6 weeks with a maximum duration of 8 weeks. At week 8, patients should be reevaluated. Care beyond 8 weeks may be indicated for certain chronic pain patients in whom manipulation is helpful in improving function, decreasing pain and improving quality of life. In these cases, treatment may be continued at 1 treatment every other week until the patient has reached plateau and maintenance treatments have been determined. Extended durations of care beyond what is considered "maximum" may be necessary in cases of re-injury, interrupted continuity of care, exacerbation of symptoms, and in those patients with comorbidities. Such care should be re-evaluated and documented on a monthly basis. Treatment beyond 4-6 visits should be documented with objective improvement in function. The documentation indicates the patient has previously undergone chiropractic treatment; however, there were no objective findings

provided that indicated functional improvement related to the chiropractic treatments. As such, the request for additional chiropractic treatments for eight (8) visits, lumbar spine is not medically necessary.