

<b>Case Number:</b>	CM13-0063328		
<b>Date Assigned:</b>	12/30/2013	<b>Date of Injury:</b>	11/25/2011
<b>Decision Date:</b>	04/16/2014	<b>UR Denial Date:</b>	11/26/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/09/2013

### 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 and Rehabilitation and is licensed to practice in Illinois. 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 61-year-old female who reported an injury on 11/25/2011 after she hit her knee against a turnstile which reportedly caused injury to her right knee. The patient's treatment history included medications, activity modifications, a knee brace, and acupuncture. The patient's most recent physical evaluation noted that the patient had sufficient pain control with medication usage. Physical findings included tenderness to palpation over the medial aspect of the right knee with limited range of motion secondary to pain, a positive McMurray's test and a positive drawer sign to the right knee. The patient's diagnoses included right lower extremity radiculopathy and neuropathy, right knee contusion, and right knee chondromalacia patella. The patient's treatment plan included acupuncture to the right lower extremity, electrodiagnostic studies, an MRI, and continuation of medication usage.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**MEDROX OINTMENT 120GM, APPLY A THIN LAYER THREE (3) TIMES DAILY:**

Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical analgesics Page(s): 105,111-113.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Medications for Chronic Pain and Topical Analgesics Page(s): 60,111.

**Decision rationale:** This is a compounded medication that contains methyl salicylate, menthol, and capsaicin. The Chronic Pain Guidelines support the use of methyl salicylate and menthol treatment of chronic pain related to osteoarthritis. The clinical documentation does support that the patient has a diagnosis of right knee osteoarthritis. However, this medication also contains capsaicin. The Guidelines do not recommend the use of capsaicin as a topical agent unless the patient has failed to respond to other first line treatments to include anticonvulsants and antidepressants. The clinical documentation submitted for review does not provide any evidence that first line medications have failed to control this patient's pain. Additionally, the Guidelines recommend that the continued use of medications for the management of a patient's chronic pain be supported by a pain assessment and documentation of functional benefit. The clinical documentation submitted for review does indicate that the patient has pain relief resulting from medication usage. However, there is no evidence of quantitative objective measures to support the patient has functional benefit related to medication usage. Therefore, continued use of this medication would not be supported. As such, the requested Medrox ointment 120 gm apply a thin layer three (3) times daily is not medically necessary or appropriate.

**NAPROXEN 550MG #90, ONE (1) TABLET TWICE DAILY:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation CA MTUS 2009: Chronic Pain Medical Treatment Guidelines, Naproxen (Naprosyn), 73

**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 Chronic Pain Guidelines recommend the use of non-steroidal anti-inflammatory drugs (NSAIDs) in the management of chronic pain. However, the clinical documentation submitted for review provides evidence that the patient has been on non-steroidal anti-inflammatory drugs for pain control since at least 12/2011. The Guidelines recommend that the continued use of medications in the management of chronic pain be supported by a pain assessment and documentation of functional benefit. The clinical documentation submitted for review does indicate that the patient has good pain control with medication usage. However, there is no evidence of quantitative objective measures provided to support that the patient has any functional benefit related to medication usage. As such, the requested naproxen 550 mg #90, one (1) tablet twice daily #90 is not medically necessary or appropriate.