

<b>Case Number:</b>	CM13-0066109		
<b>Date Assigned:</b>	01/03/2014	<b>Date of Injury:</b>	09/07/2006
<b>Decision Date:</b>	04/17/2014	<b>UR Denial Date:</b>	11/27/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/16/2013

### 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 Anesthesiologist, has a subspecialty in Pain Medicine, and is licensed to practice in Florida. 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 52-year-old female who reported an injury on 09/07/2006. The mechanism of injury was not provided for review, but the patient reportedly sustained an injury to her left knee that failed to respond to initial conservative treatments and ultimately required left knee arthroscopy with debridement of a prepatellar bursitis. The patient's postoperative treatment history included physical therapy and medications. The patient was regularly monitored for aberrant behavior with urine drug screens. The patient's clinical evaluation on the requested date of service for 10/31/2013 documented that the patient had a normal gait without assistive devices with tenderness to palpation of the patellofemoral joint, crepitus of the patellofemoral joint and evidence of atrophy with a positive compression test. The patient's diagnoses included chondromalacia patella, derangement of the medial meniscus and derangement of the lateral meniscus. The patient's treatment recommendations included hyaluronic injections, physical therapy and the continuation of medications. The patient's medication schedule included Norco, tramadol and Protonix.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**RETROSPECTIVE REQUEST FOR PROTONIX 20MG, ONE (1) QD, #60, DOS 10/31/2013: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Section nonsteroidal anti-inflammatory drugs (NSAIDs), gastrointestinal (GI) symptoms & cardiova.

**Decision rationale:** The California Medical Treatment Utilization Schedule recommends a gastrointestinal protectant for patients who are at risk for developing gastrointestinal events 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 they are at risk for developing gastrointestinal events. As such, the requested Protonix 20 mg 1 every day #60 for the date of service of 10/31/2013 is not medically necessary or appropriate.

**RETROSPECTIVE REQUEST FOR VOLTAREN XR 100MG, ONE (1) QD, #60, DOS 10/31/2013:** Upheld

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

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

**Decision rationale:** The California Medical Treatment Utilization Schedule does support the use of nonsteroidal anti-inflammatory drugs as appropriate for the management of chronic pain. However, the clinical documentation submitted for review does indicate that the patient has been using Norco and tramadol for pain control for an extended period of time. The patient's evaluation from the date of service of 10/31/2013 does not provide an adequate pain assessment to support the need for additional medication. No quantitative measures were provided to support the efficacy of the requested medication. As such, the retrospective request for Voltaren XR 100 mg once per day #60 for the date of service of 10/31/2013 is not medically necessary or appropriate.

**RETROSPECTIVE REQUEST FOR NORCO 10/325MG, ONE (1) Q6H PRN, #60 DOS 10/31/2013:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Section Opioids, On-going Management Page(s): 78.

**Decision rationale:** The California Medical Treatment Utilization Schedule recommends that continued use of opioids for the management of chronic pain be supported by a quantitative assessment of pain relief, documentation of functional benefit, managed side effects and evidence that the patient is monitored for aberrant behavior. The clinical documentation submitted for review does indicate that the patient has been on this medication since 2012. The clinical documentation does indicate that the patient is monitored for aberrant behavior. However, the patient's evaluation for the requested date of service of 10/31/2013 does not

provide an adequate assessment of pain relief. Additionally, there was no documentation of functional benefit to support the continued use of opioids in the management of chronic pain. As such, the retrospective request for Norco 10/325 mg 1 every 6 hours as needed for the date of service of 10/31/2013 is not medically necessary or appropriate.

**RETROSPECTIVE REQUEST FOR ULTRAM 50MG, ONE (1) Q4-6H PRN, #60, DOS 10/31/2013: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Section Opioids, On-going Management Page(s): 78.

**Decision rationale:** The California Medical Treatment Utilization Schedule recommends that continued use of opioids for the management of chronic pain be supported by a quantitative assessment of pain relief, documentation of functional benefit, managed side effects and evidence that the patient is monitored for aberrant behavior. The clinical documentation submitted for review does indicate that the patient has been on this medication since 2012. The clinical documentation does indicate that the patient is monitored for aberrant behavior. However, the patient's evaluation for the requested date of service of 10/31/2013 does not provide an adequate assessment of pain relief. Additionally, there was no documentation of functional benefit to support the continued use of opioids in the management of chronic pain. As such, the retrospective request for Ultram 50 mg 1 every 4 to 6 hours as needed #60 for the date of service of 10/31/2013 is not medically necessary or appropriate.

**RETROSPECTIVE REQUEST FOR TOPICAL LOTION (MENTHODERM GEL) 120ML, #1, DOS 10/31/2013: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Section Topical Analgesics and Salicylate topicals and Page(s): 111 105.

**Decision rationale:** The California Medical Treatment Utilization Schedule does recommend the use of methyl salicylates in the management of osteoarthritic-related pain. However, the clinical documentation submitted for review does not provide an adequate pain assessment to support the need for this type of medication. The California Medical Treatment Utilization Schedule states that topical analgesics are largely experimental and are supported by very few scientific studies. Therefore, the efficacy and safety cannot be established. As such, the retrospective request for topical lotion (Menthoderm gel) 120 mL #1 for date of service of 10/31/2013 is not medically necessary or appropriate.