

Case Number:	CM14-0007101		
Date Assigned:	02/07/2014	Date of Injury:	04/10/2008
Decision Date:	07/07/2014	UR Denial Date:	01/03/2014
Priority:	Standard	Application Received:	01/15/2014

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 Occupational Medicine 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 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:

Patient is a 62-year-old female who has submitted a claim for left medial meniscus persistent tear versus re-tear, right knee degenerative joint disease and popliteal cyst, s/p arthroscopic left partial and medial meniscectomy associated with an industrial injury date of 4/10/2008. Medical records from 2012-2013 were reviewed which revealed persistent bilateral knee pain graded 9/10. Sleep disturbances were noted due to pain. Physical examination showed medial and lateral facet tenderness. Patellar crepitus was noted. Lateral McMurray and Medial McMurray tests were positive. Patellar apprehension, valgus, varus, posterior drawer, posterolateral rotator instability, anterior drawer, Lachman, pivot shift tests were negative. MR arthrogram done on 11/11/13 revealed complex tear of the posterior horn and body of the lateral meniscus. Degenerative changes on the posterior horn and body of medial meniscus were seen. Degenerative joint disease of the lateral medial compartments and severe patellofemoral chondromalacia were also noted. Treatment to date has included, left knee arthroscopic procedure done on 1/30/13, CT-guided aspiration of Baker's cyst, physical therapy and acupuncture sessions, cortisone injections and electrical stimulation. Medications given were, topical lidocaine, salicylates, menthol and capsaicin. Utilization review from 1/13/14 denied the retrospective requests for #30 Terocin Patch, Flurbi (NAP) Cream-LA 180 mg and #30 Somnicin. Terocin patch was denied because no neuropathic pain was documented at either knee in order to warrant the lidocaine component. Regarding Flurbiprofen cream, it was denied because it contains at least one drug that is not recommended by the guidelines. Lastly, Somnicin was denied because there was no evidence supporting the need for this drug.

IMR ISSUES, DECISIONS AND RATIONALES

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

RETROSPECTIVE REQUEST FOR TEROGIN PATCH #30: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 2009, 9792.20 - 9792.26, Lidoderm (lidocaine patch) Page(s): 56-57.

Decision rationale: As stated on pages 56-57 of the California MTUS Chronic Pain Medical Treatment Guidelines, Terogin Patch is recommended for localized peripheral pain after there has been evidence of a trial of first-line therapy (tri-cyclic or SNRI anti-depressants or an AED such as Gabapentin or Lyrica). In this case, patient's medical records did not document a trial of first-line therapy. In addition, her pain is not neuropathic in nature. Therefore, the retrospective request for terogin patch #30 is not medically necessary.

RETROSPECTIVE REQUEST FOR 1 PRESCRIPTION FOR FLURBI (NAP) CREAM-LA 180 MG: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 2009, 9792.24.2, Topical Analgesics Page(s): 111-113.

Decision rationale: As stated on pages 111-113 of the California MTUS Chronic Pain Medical Treatment Guidelines, any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Topical analgesics are largely experimental in use with few randomized controlled trials to determine safety or efficacy. In this case, FLURBI (NAP) CREAM-LA contains 3 active ingredients: Flurbiprofen 20%, Lidocaine 5% and Amitriptyline 5%. Regarding Flurbiprofen, CA MTUS supports a limited list of NSAID topical, which does not include Flurbiprofen. Regarding Lidocaine component, CA MTUS Chronic Pain Medical Treatment Guidelines identify on page 112 that topical formulations of lidocaine (whether creams, lotions or gels) are not indicated for neuropathic or non-neuropathic pain complaints. Lastly, Amitriptyline is only indicated for neuropathic pain in oral formulation. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. There is no discussion in the documentation concerning the need for use of unsupported topical analgesics. Therefore, the request for 1 prescription for flurbi (nap) cream-la 180 mg is not medically necessary.

RETROSPECTIVE REQUEST FOR SOMNICIN #30: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

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 Section.

Decision rationale: The CA MTUS does not address this topic. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, Official Disability Guideline, Pain Chapter, Insomnia Section was used instead. The Official Disability Guidelines (ODG) recommends that treatment of insomnia be based on etiology. Pharmacological agents should only be used after careful evaluation of potential causes of sleep disturbance. There are four main categories of pharmacologic treatment: (1) Benzodiazepines; (2) Non-benzodiazepines; (3) Melatonin & melatonin receptor agonists; & (4) Over-the-counter medications. In this case, patient was prescribed Somnicin for sleep disturbance, which is composed of melatonin, 5-HTP, L-tryptophan, B6 and magnesium. However, there was no mention in the documents provided regarding the sleep hygiene of the patient. Furthermore, there was no evaluation done as to the potential cause of patient's sleep disturbance. Therefore, the retrospective request for Somnicin #30 is not medically necessary.