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| Case Number: | CM14-0133229 | | |
| Date Assigned: | 08/22/2014 | Date of Injury: | 12/08/2010 |
| Decision Date: | 10/09/2014 | UR Denial Date: | 08/04/2014 |
| Priority: | Standard | Application Received: | 08/20/2014 |

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 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 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 male who reported injury on 12/08/2010. The mechanism of injury and diagnostic studies were not provided. The diagnosis included internal derangement bilateral knees, recurrent dislocation shoulder, carpal tunnel syndrome, hypertension nos, and pain in limb. The injured worker's medications were noted to include ketoprofen 75 mg, hydrocodone 5/325 mg, and zolpidem tartrate 10 mg as of 11/20/2013. The surgical history included a total knee replacement and therapy. The documentation of 07/23/2014 revealed the injured worker was taking his medications as prescribed. The physical examination revealed the right shoulder had well healed arthroscopic portals. The range of motion was restricted in flexion and abduction. The impingement sign was positive. The injured worker's bilateral medial elbows were tender to palpation. The Tinel's sign was positive on the left. The injured worker had atrophy of muscles bilaterally. Grip strength was reduced. Sensation was reduced in the bilateral hands and the Tinel's sign and Phalen's sign were positive bilaterally. The injured worker had effusion in the right knee and the joints were tender to palpation. There was a positive McMurray's bilaterally. The treatment plan included bilateral knee braces and refill of the medications. The refills included omeprazole DR 20 mg capsules 1 daily with 1 refill, zolpidem tartrate 10 mg 1 at bedtime with 1 refill, Medrox pain ointment apply to affected area twice a day refill x2, hydrocodone 5/325 1 tablet by mouth twice a day #60 refill 1, and naproxen sodium 550 mg. There was no Request for Authorization submitted for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Bilateral Knee Braces: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Page(s): unspecified.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 346.

Decision rationale: The American College of Occupational and Environmental Medicine indicates that a knee brace can be utilized for patellar instability, anterior cruciate ligament tear, or medial collateral ligament instability. Additionally, it indicates that usually a brace is necessary only if the injured worker is going to be stressing the knee under load, such as climbing ladders or carrying boxes. The clinical documentation submitted for review failed to provide a documented rationale for the request. Given the above, the request for Bilateral Knee Braces not medically necessary.

Ketoprofen 75mg #30: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS Page(s): 67.

Decision rationale: The California MTUS Guidelines recommend NSAIDs for the short term symptomatic relief of low back pain. There should be documentation of objective functional improvement and an objective decrease in pain. The clinical documentation submitted for review indicated the injured worker had utilized the medication since late 2013. There was a lack of documentation of the above criteria. The request as submitted failed to indicate the frequency for the requested medication. Given the above, the request for Ketoprofen 75mg #30 is not medically necessary.

Omeprazole Dr 20mg #30: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS, Page(s): 69.

Decision rationale: The California MTUS Guidelines indicate that proton pump inhibitors are recommended for injured workers at intermediate or high risk for gastrointestinal events. Additionally, they indicate that proton pump inhibitors are appropriate for the treatment of dyspepsia secondary to NSAID therapy. The clinical documentation submitted for review failed to provide documented efficacy. The duration of use could not be established. The request as submitted failed to indicate the frequency for the requested medication. Additionally, the NSAID was found to be not medically necessary, and as such, the request for omeprazole would

not be support. Given the above, the request for Omeprazole Dr 20mg #30 is not medically necessary.

Medrox Pain Relief Ointment: 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 Salicylate, Topical Analgesic, Topical Capsaicin Page(s): 105, 111, 28. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Medrox Online Package Insert

Decision rationale: The California MTUS indicates that topical analgesics are largely experimental in use with few randomized control trials to determine efficacy or safety... are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed....Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended....Capsaicin: Recommended only as an option in patients who have not responded or are intolerant to other treatments....There have been no studies of a 0.0375% formulation of capsaicin and there is no current indication that this increase over a 0.025% formulation would provide any further efficacy. Additionally it indicates that Topical Salicylates are approved for chronic pain. According to the Medrox package insert, Medrox is a topical analgesic containing Menthol 5.00% and 0.0375% Capsaicin and it is indicated for the "temporary relief of minor aches and muscle pains associated with arthritis, simple backache, strains, muscle soreness, and stiffness. The clinical documentation submitted for review failed to provide documentation of exceptional factors to warrant nonadherence to guidelines recommendations. The duration of use could not be established; however, it was indicated the injured worker had utilized the medication previously. There was a lack of documentation of objective functional benefit. The request as submitted failed to indicate the frequency, quantity, strength, and the body part to be treated for the requested medication. Given the above, the request for Medrox Pain Relief Ointment is not medically necessary.

Zolpidem Tartrate 10 MG #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, Zolpidem

Decision rationale: The Official Disability Guidelines indicate that zolpidem is appropriate for the short term treatment of insomnia. The clinical documented submitted for review indicated the injured worker had utilized the medication since at least late 2013. There was a lack of documentation indicating objective functional benefit and exceptional factors to warrant nonadherence to guideline recommendations. The request as submitted failed to indicate the

frequency for the requested medication. Given the above, the request for Zolpidem Tartrate 10 Meredith G. #30 is not medically necessary.

Hydrocodone (Norco) 5/325mg #30: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Medications for Chronic pain, page 60, ongoing management, Page(s): 78.

Decision rationale: The California MTUS Guidelines recommend opioids for the treatment of chronic pain. There should be documentation of objective functional improvement and objective decrease in pain and documentation the injured worker is being monitored for aberrant drug behavior and side effects. The clinical documentation submitted for review failed to meet the above criteria. The duration of use was since at least late 2013. The request as submitted failed to indicate the frequency for the requested medication. Given the above, the request for Hydrocodone (Norco) 5/325mg #30 is not medically necessary.