

Case Number:	CM14-0155582		
Date Assigned:	09/25/2014	Date of Injury:	09/01/2007
Decision Date:	10/27/2014	UR Denial Date:	09/02/2014
Priority:	Standard	Application Received:	09/23/2014

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 Anesthesiology, 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 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 52-year-old female, who reported a date of injury of 09/01/2007. The mechanism of injury was reported as a fall. The injured worker had diagnoses of meniscal tear and lower leg joint pain. Prior treatments were not indicated within the medical records provided. The injured worker had an MRI of the right knee on 12/13/2013 with an unofficial report indicating focal tear at coronary ligament insertion at the posterior horn medial meniscal capsular junction without displaced meniscal fragment or progression. There was also evidence of supralateral fat pad impingement without evidence of patella alta. Surgeries included arthroscopy of the right knee with partial medial meniscectomy, chondroplasty of the medial femoral condyle, partial lateral meniscectomy with patelloplasty, partial synovectomy. The injured worker had complaints of continued knee pain since surgery with a crunching noise when bending, and rated the pain 7/10. The clinical note, dated 05/14/2014, noted the injured worker had throbbing pain with pressure to the knee and reports that the medication was not helping, ambulation with the assistance of a cane. Medications were not indicated. The treatment plan included the physician's recommendation for postoperative physical therapy and to return in 6 weeks. The rationale and Request for Authorization form were not provided within the medical records received.

IMR ISSUES, DECISIONS AND RATIONALES

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

40 Capsules of Hydrocodone/APAP/Ondansetron 10/300/2mg: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 78.4. Decision based on Non-MTUS Citation Official Disability Guidelines

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use Page(s): 78. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain (Chronic), Compound drugs.

Decision rationale: The request for 40 Capsules of Hydrocodone/APAP/Ondansetron 10/300/2mg is not medically necessary. The injured worker had complaints of continued knee pain since surgery with a crunching noise when bending, and rated the pain 7/10. The California MTUS Guidelines recommend opioids with the lowest possible dose being prescribed to improve pain and function, ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. Pain assessment should include the current pain, the least reported pain over the period since last assessment, average pain, intensity of pain after taking opioid, how long it takes for the pain relief, and how long pain relief lasts. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. The Official Disability Guidelines state compounded drugs are not recommended as a first line therapy. In general, commercially available, FDA approved drugs should be given an adequate trial. If these are found to be ineffective or are contraindicated in individual patients, compound drugs that use FDA approved ingredients may be considered. Medical necessity should be based on the patient's needs combined with medical and scientific evidence. There is a lack of documentation of an accurate pain assessment of the injured worker's pain relief, functional status, and appropriate medication use. The injured worker is noted to have been prescribed hydrocodone at least since the 06/02/2014 physical therapy evaluation, with a lack of documentation indicative of effectiveness. Furthermore, the guidelines indicate individual FDA approved drugs should be given an adequate trial prior to compounded drugs. There is a lack of documentation indicating the injured worker has failed the treatment with hydrocodone and Zofran independently. There is a lack of documentation indicating the injured worker was experiencing nausea or vomiting with the use of hydrocodone to warrant the use of Zofran. Additionally, the request as submitted did not specify a frequency of the medication use. As such, the request is not medically necessary.

Flurbiprofen 20% Cyclobenzprine 10% Menthol 4% Cream 180 grams: 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): 111-112.

Decision rationale: The request for Flurbiprofen 20% Cyclobenzprine 10% Menthol 4% Cream 180 grams is not medically necessary. The injured worker had complaints of continued knee pain since surgery with a crunching noise when bending, and rated the pain 7/10. The California MTUS Guidelines indicate topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Also, indicated for osteoarthritis and tendinitis, in particular that of the knee and elbow or other joints that are amenable to topical

treatment. Recommended for short term use of 4 to 12 weeks. Any compounded product that contains at least 1 drug that is not recommended is not recommended. There is a lack of documentation indicating the injured worker has failed antidepressants or anticonvulsants, for which the guidelines indicate as a first line treatment for neuropathic pain. There is a lack of documentation the injured worker has neuropathic pain, and the injured worker is noted to have postsurgical pain, for which the guidelines do not recommend use. Furthermore, the request as submitted did not specify a frequency of use. As such, the request is not medically necessary.

Keratek Gel 4 oz: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-112.

Decision rationale: The request for Keratek Gel 4% is not medically necessary. The injured worker had complaints of continued knee pain since surgery with a crunching noise when bending, and rated the pain 7/10. The California MTUS Guidelines indicate topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Also, indicated for osteoarthritis and tendinitis, in particular that of the knee and elbow or other joints that are amenable to topical treatment. Recommended for short term use of 4 to 12 weeks. Any compounded product that contains at least 1 drug that is not recommended is not recommended. There is a lack of documentation indicating the injured worker has failed antidepressants or anticonvulsants or has neuropathic pain, for which the guidelines indicate the use of topical analgesics. Furthermore, the injured worker is noted to have postsurgical pain, for which the guidelines do not recommend use. Additionally, the request as submitted did not specify a frequency of the medication's use. As such, the request is not medically necessary. .