

<b>Case Number:</b>	CM14-0027324		
<b>Date Assigned:</b>	06/13/2014	<b>Date of Injury:</b>	03/14/2003
<b>Decision Date:</b>	08/13/2014	<b>UR Denial Date:</b>	02/28/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/04/2014

### 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 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:

The injured worker is a 55-year-old male who reported an injury on 03/14/2003. The mechanism of injury was not provided. On 02/21/2014, the injured worker presented with bilateral knee and left ankle pain. Upon examination, there was mild swelling and point tenderness over the medial and lateral malleolus. The examination of the knee revealed mild swelling and tenderness. The diagnoses were knee pain and pain in limb. Current medications include hydrocodone, Voltaren gel, Dendracin cream, and Naprosyn. The provider recommended hydrocodone, Voltaren gel, Dendracin, and Naprosyn; the provider's rationale was not provided. The request for authorization form was not included in the medical documents for review.

### IMR ISSUES, DECISIONS AND RATIONALES

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

#### **HYDROCODONE/APAP 10/325MG #180: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines OPIOIDS Page(s): 91.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opiods, Criteria for use Page(s): 78.

**Decision rationale:** The request for hydrocodone/APAP 10/325mg #180 is not medically necessary. The California MTUS Guidelines recommend providing ongoing education of both

the benefits and limitations of opioid treatment. The Guidelines recommend the lowest dose be prescribed to improve pain and function. Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects is recommended. A pain assessment should include pain, least reported pain over the period since the last assessment, average pain, intensity of pain after taking the opioid, how long it takes for pain relief, and how long pain relief lasts. Satisfactory response to treatment may be indicated by the injured worker's decrease in pain and increased function or improved quality of life. The provided medical documentation lacked evidence of the injured worker's failure to respond to a nonopioid analgesic. The documentation lacks efficacy of the medication, and a complete and adequate pain assessment was not provided. The provider's request does not indicate the frequency of the medication in the request as submitted. As such, the request is not medically necessary.

**VOLTAREN GEL 1% #2 WITH 1 REFILL:** 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.

**Decision rationale:** The request for Voltaren gel 1% #2 with 1 refill is not medically necessary. The California MTUS Guidelines state that transdermal compounds are largely experimental in use with few randomized controlled trials to determine efficacy or safety. Topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Any compounded product that contains at least 1 drug or drug class that is not recommended is not recommended. The Guidelines note that topical NSAIDs are recommended for osteoarthritis and tendonitis, in particular, that of the knee or elbow and other joints that are amenable to topical treatment. The recommended use is 4 to 12 weeks. There is little evidence to utilize topical NSAIDs for treatment of osteoarthritis of the spine, hip, or shoulder. The documentation lacked evidence that the injured worker had a diagnosis congruent with the Guidelines recommendations for topical NSAIDs. Additionally, the provider's request does not indicate the site that the gel is indicated for or the frequency of the medication in the request as submitted. As such, the request is not medically necessary.

**DENDRACIN CREAM #2:** 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. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Dendracin, Online Drug Insert.

**Decision rationale:** The request for Dendracin cream #2 is not medically necessary. The California MTUS indicate that topical salicylates are recommended and topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety.

They are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Any compounded product that contains at least 1 drug or drug class that is not recommended is not recommended. Benzocaine is similar to lidocaine and lidocaine is only recommended in a Lidoderm patch. Per the Online Drug Insert, Dendracin includes methyl salicylate, benzocaine, and menthol and is used for temporary relief of minor aches and pains caused by arthritis, simple back ache, and strains. The included documentation does not indicate that the injured worker failed a trial of antidepressants or anticonvulsants. The Dendracin cream contains lidocaine which is only recommended in a Lidoderm patch. Additionally, the provider's request does not indicate the dose, frequency, or site that the Dendracin cream is intended for in the request as submitted. As such, the request is not medically necessary.

**NAPROSYN 500MG #120:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): 67-73.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): 70.

**Decision rationale:** The request for Naprosyn 500 mg #120 is not medically necessary. The California MTUS state NSAIDs are recommended for injured workers with osteoarthritis including knee and hip and injured workers with acute exacerbations of chronic low back pain. The Guidelines recommend NSAIDs at the lowest dose for the shortest period in injured workers with moderate to severe pain. Acetaminophen may be considered for initial therapy for injured workers with mild to moderate pain and in particular for those with gastrointestinal, cardiovascular, or renovascular risk factors. The included documentation lacked evidence of a complete and adequate pain assessment of the injured worker. The efficacy of the medication was not provided. Additionally, the provider's request does not indicate the frequency of the medication in the request as submitted. As such, the request is not medically necessary.