

<b>Case Number:</b>	CM14-0035839		
<b>Date Assigned:</b>	06/23/2014	<b>Date of Injury:</b>	01/14/2005
<b>Decision Date:</b>	07/22/2014	<b>UR Denial Date:</b>	02/24/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/24/2014

### 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 Pain Medicine and is licensed to practice in Texas and Oklahoma. 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 50-year-old female who reported an injury on 01/14/2005. The mechanism of injury was not provided for review. The injured worker reportedly sustained an injury to her low back and bilateral knees. Treatment history included multiple medications, physical therapy, a home exercise program, and injections. Evaluation on 02/24/2014, documented that she had continued pain complaints of the low back and bilateral knees. Physical findings included restricted range of motion of the bilateral knees. Diagnoses included post-traumatic lumbar spine sprain/strain, residual tear of the medial body of the medial meniscus of the left knee, and tricompartmental osteoarthritis of the right knee. Treatment plan included continuation of medications to include Lorcet plus 7.5/650 mg, Mobic 15 mg, and Ambien 10 mg.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Pharmacy purchase of Hydrocodone/APAP 735/650 mg:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM.

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

**Decision rationale:** The clinical documentation submitted for review does indicate that the injured worker has been on this medication for an extended duration of treatment. California Medical Treatment Utilization Schedule recommends that continued use of opioids be supported by documentation of functional benefit, a quantitative assessment of pain relief, managed side effects, and evidence that the injured worker is monitored for aberrant behavior. The clinical documentation submitted for review does not provide any evidence of functional benefit or pain relief resulting from medication usage. Additionally, there is no documentation that the injured worker is monitored for aberrant behavior. Therefore, continued use of this medication would not be supported. Furthermore, the request does not specifically identify a quantity or frequency of treatment. In the absence of this information, the appropriateness of the request itself cannot be determined. As such, the request for pharmacy purchase of hydrocodone/APAP "735/650" mg is not medically necessary and appropriate.

**Meloxicam 15 mg:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Chronic pain and NSAIDs (non-steroidal anti-inflammatory drugs) Page(s): 60 and 16.

**Decision rationale:** California MTUS recommends the ongoing use of nonsteroidal anti-inflammatory drugs in the management of chronic pain be supported by functional benefit and pain relief. The clinical documentation submitted for review fails to identify any functional benefit or pain relief resulting from the use of medications. Therefore, continued use of this medication would not be supported. Additionally, the request as it is submitted does not clearly identify a quantity or frequency of treatment. In the absence of this information, the appropriateness of the request itself cannot be determined. As such, the request for Meloxicam 15 mg is not medically necessary and appropriate.

**Terocin lotion:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM. Decision based on Non-MTUS Citation Physician's Desk Reference.

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

**Decision rationale:** The requested medication is a compounded medication with methyl salicylate, menthol, capsaicin, and lidocaine. California Medical Treatment Utilization Schedule does recommend the use of methyl salicylate and menthol in the management of osteoarthritic-related pain. However, California Medical Treatment Utilization Schedule recommends the use of capsaicin be limited to patients who have failed to respond to first-line medications such as antidepressants and anticonvulsants. The clinical documentation fails to provide any evidence that the injured worker has failed to respond to these first-line medications. Therefore the use of capsaicin as a topical analgesic would not be indicated. Additionally, the California Medical Treatment Utilization Schedule does not support the use of lidocaine in a cream formulation, as it

is not FDA-approved to treat neuropathic pain. MTUS Guidelines does not recommend the use of any medication that contains at least 1 drug or drug class that is not supported by guideline recommendations. Furthermore, the request as it is submitted does not include a quantity, frequency of treatment, or specified body part for application. In the absence of this information, the appropriateness of the request itself cannot be determined. As such, the request for Terocin lotion is not medically necessary and appropriate.

**Zolpidem 10 mg:** Upheld

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

**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 Treatments.

**Decision rationale:** The California Medical Treatment Utilization Schedule does not specifically address this medication. The Official Disability Guidelines recommend short durations of treatment of Ambien for chronic pain-related insomnia. The clinical documentation submitted for review does indicate that the injured worker has been on this medication for an extended duration. Therefore, continued use would not be supported. Additionally, the most recent clinical documentation does not provide an adequate assessment of the injured worker's sleep hygiene to support continued use and the need for pharmacological intervention. Furthermore, the request as it is submitted does not clearly identify a quantity or frequency of treatment. In the absence of this information, the appropriateness of the request itself cannot be determined. As such, the request for Zolpidem 10 mg is not medically necessary and appropriate.