

<b>Case Number:</b>	CM14-0080359		
<b>Date Assigned:</b>	07/18/2014	<b>Date of Injury:</b>	02/01/2003
<b>Decision Date:</b>	09/17/2014	<b>UR Denial Date:</b>	05/02/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/02/2014

### 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 & 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:

According to the records made available for review, the injured worker is a 69-year-old female with a 2/1/03 date of injury. There is documentation of subjective findings of low back and bilateral knee pain and reports pain has worsened lately. Current diagnoses are right knee internal derangement, chronic pain syndrome, mechanical low back pain, morbid obesity (exacerbated by industrial injury), prescription narcotic dependence, chronic pain-related insomnia, chronic pain-related depression, and neuropathic pain. Treatment to date includes medications including ongoing treatment with OxyContin, Cymbalta, and Flexeril.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**1 urine drug screen:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Substance Abuse( Tolerance, Dependence, Addiction). Decision based on Non-MTUS Citation University of Michigan Health System Guidelines for Clinical Care: Managing Chronic Non-Terminal Pain, Including Prescribing Controlled Substances (May 2009), Page 33.

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

**Decision rationale:** MTUS Chronic Pain Medical Treatment Guidelines identifies documentation of abuse, addiction, or poor pain control in patient under on-going opioid treatment, as criteria necessary to support the medical necessity of Urine Drug Screen. Within the medical information available for review, there is documentation of diagnoses of right knee internal derangement, chronic pain syndrome, mechanical low back pain, morbid obesity (exacerbated by industrial injury), prescription narcotic dependence, chronic pain-related insomnia, chronic pain-related depression, and neuropathic pain. In addition, there is documentation of on-going opioid treatment. However, there is no documentation of abuse, addiction, or poor pain control. Therefore, based on guidelines and a review of the evidence, the request for 1 urine drug screen is not medically necessary.

**1 MRI of the left knee:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 343.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 344-347. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee, Magnetic resonance imaging (MRI).

**Decision rationale:** MTUS /ACOEM Guidelines identifies documentation of an unstable knee with documented episodes of locking, popping, giving way, recurrent effusion, or clear signs of a bucket handle tear, as well as nondiagnostic radiographs, as criteria necessary to support the medical necessity of MRI of the knee. The Official Disability Guidelines (ODG) identifies documentation of a condition/diagnosis (with supportive subjective/objective findings) for which an MRI of the knee is indicated (such as: acute trauma to the knee, including significant trauma, or if suspect posterior knee dislocation or ligament or cartilage disruption; Nontraumatic knee pain; initial anteroposterior and lateral radiographs nondiagnostic; patellofemoral (anterior) symptoms; initial anteroposterior, lateral, and axial radiographs nondiagnostic; nontrauma, non-tumor, non-localized pain; or initial anteroposterior and lateral radiographs demonstrate evidence of internal derangement), as criteria necessary to support the medical necessity of MRI of the knee. Within the medical information available for review, there is documentation of diagnoses of right knee internal derangement, chronic pain syndrome, mechanical low back pain, morbid obesity (exacerbated by industrial injury), prescription narcotic dependence, chronic pain-related insomnia, chronic pain-related depression, and neuropathic pain. However, there is no documentation of an unstable knee with documented episodes of locking, popping, giving way, recurrent effusion, or clear signs of a bucket handle tear, as well as nondiagnostic radiographs. In addition, there is no documentation of a condition/diagnosis (with supportive subjective/objective findings) for which an MRI of the knee is indicated (nondiagnostic radiographs). Therefore, based on guidelines and a review of the evidence, the request for 1 MRI of the left knee is not medically necessary.

**1 prescription of Trepadone #60:** Upheld

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

**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, Medical Food and <http://www.ptlcentral.com/medical-foods-products.php>.

**Decision rationale:** An online source identifies Trepadone as a Medical Food, consisting of a proprietary formulation of amino acids and polyphenol ingredients in specific proportions, for the dietary management of the altered metabolic processes associated with pain and inflammation related to joint disorders. MTUS does not address the issue. MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. The Official Disability Guidelines (ODG) identifies that the product must be a food for oral or tube feeding; must be labeled for dietary management of a specific medical disorder, disease, or condition for which there are distinctive nutritional requirements; and must be used under medical supervision; as criteria to support the medical necessity of medical food. Within the medical information available for review, there is documentation of a diagnosis of right knee internal derangement, chronic pain syndrome, mechanical low back pain, morbid obesity (exacerbated by industrial injury), prescription narcotic dependence, chronic pain-related insomnia, chronic pain-related depression, and neuropathic pain. In addition, there is documentation that Trepadone is for oral use and being used under medical supervision. However, there is no documentation that Trepadone is labeled for dietary management of a specific medical disorder, disease, or condition for which there are distinctive nutritional requirements. Therefore, based on guidelines and a review of the evidence, the request for 1 prescription of Trepadone #60 is not medically necessary.

**1 prescription of GL hot ointment:** 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 Topical Analgesics Page(s): 111. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Title 8, California Code of Regulations, section 9792.20.

**Decision rationale:** MTUS Chronic Pain Medical Treatment Guidelines identifies that topical analgesics are recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. Within the medical information available for review, there is documentation of a diagnosis of right knee internal derangement, chronic pain syndrome, mechanical low back pain, morbid obesity (exacerbated by industrial injury), prescription narcotic dependence, chronic pain-related insomnia, chronic pain-related depression, and neuropathic pain. In addition, there is documentation of neuropathic pain and a plan to start GL hot ointment. However, there is

no documentation that trials of antidepressants and anticonvulsants have failed. Therefore, based on guidelines and a review of the evidence, the request for 1 prescription of GL hot ointment is not medically necessary.