

<b>Case Number:</b>	CM14-0199555		
<b>Date Assigned:</b>	12/10/2014	<b>Date of Injury:</b>	01/09/2002
<b>Decision Date:</b>	01/27/2015	<b>UR Denial Date:</b>	11/19/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/01/2014

### 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 Rehab, has a subspecialty in Neuromuscular Medicine and is licensed to practice in Maryland. 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 patient is a 59 year old male with a work injury dated 1/9/02. The diagnoses include left total knee replacement with residual flexion instability and arthrofibrosis; post left knee arthroscopy procedure for resection of medial meniscal tear; probable right knee degenerative joint disease; nonindustrial; chronic low back pain related to facet osteoarthritis. The patient is status post right knee arthroscopy 3/6/02 and left total knee replacement Feb. 2011. Under consideration are requests for Norco 10/325mg #90; Soma 350mg #60; Voltaren gel 1% 2gm #2; Pennsaid 1.5%. There is a progress note dated 11/10/14 that states that the patient has bilateral knee pain with associated low back pain. The patient presents with complaints of left knee pain. The patient states that the first 6 months after his knee replacement which was in Feb. of 2011 he was making good progress but since he has intermittent knee pain and fluid build up. His pain is significantly worse with activity. His last x-ray was reviewed by a physician who stated that "there is nothing in the joint that is loose or wrong. " He was unable to receive his medications due to conflict with State Fund. On exam the patient ambulates with an antalgic gait favoring the left side. The lumbar spine reveals tenderness and tightness across the lumbosacral area with decreased range of motion. There is a negative straight leg raise and a negative Patrick's sign. The left knee exam reveals a well healed midline anterior surgical scar. There is 1+ effusion. There is tenderness around the joint space. The range of motion is 0-95. The right knee exam revealed tenderness in the prepatellar area with range of motion from 0-145 degrees. There is positive crepitus bilaterally. Patellar tracking appeared normal in both knees. There is a negative Drawer sign. The varus/valgus stress were normal. The patellar reflex was 1+ on right and absent on the left. Achilles reflex were hyporeactive bilaterally. The sensory exam was grossly normal and motor was 5/5. The treatment plan was Norco, Ibuprofen, Soma, Sample of Voltaren Gel, Pennsaid.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Norco 10/325mg #90:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines On-Going Management Page(s): 78-80.

**Decision rationale:** Norco 10/325mg #90 is not medically necessary per the MTUS Chronic Pain Medical Treatment Guidelines. The documentation indicates that the patient has been on Norco dating back to April of 2014. The documentation does not indicate evidence of functional improvement as defined by the MTUS. The MTUS Chronic Pain Medical Treatment Guidelines state that a pain assessment should include: current pain; the least reported pain over the period since 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 patient's decreased pain, increased level of function, or improved quality of life. The MTUS does not support ongoing opioid use without improvement in function or pain. The documentation submitted reveals that the patient has been on Norco dating back to April 2014 without significant functional improvement therefore the request for Norco 10/325mg #90 is not medically necessary.

**Soma 350mg #60:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Carisoprodol (Soma) Page(s): 29. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain (Chronic)- Carisoprodol (Soma®)

**Decision rationale:** Soma 350mg #60 is not medically necessary per the MTUS and ODG Guidelines. Both guidelines recommend against using Soma and state that it is not for long term use. The MTUS and ODG guidelines state that abuse has been noted for sedative and relaxant effects. Carisoprodol abuse has also been noted in order to augment or alter effects of other drugs. The documentation indicates that the patient has been on Soma long term (consistently since at least April of 2014 but has used dating back to 2012) which is against guideline recommendations. There are no extenuating circumstances that would warrant the continuation of this medication. The request for Soma is not medically necessary.

**Voltaren gel 1% 2gm #2:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical analgesics Page(s): 111-113. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain(chronic)-Diclofenac, topical (Flector<sup>®</sup>, Pennsaid<sup>®</sup>, Voltaren<sup>®</sup> Gel)

**Decision rationale:** Voltaren gel 1% 2gm #2 is not medically necessary per the MTUS Chronic Pain Medical Treatment Guidelines. The ODG states that Voltaren gel is not recommended as a first-line treatment, but recommended as an option for patients at risk of adverse effects from oral NSAIDs. The MTUS states that Voltaren Gel 1% (diclofenac) is indicated for relief of osteoarthritis pain in joints that lend themselves to topical treatment (ankle, elbow, foot, hand, knee, and wrist). It has not been evaluated for treatment of the spine, hip or shoulder. Voltaren Gel is to be used for osteoarthritis and tendinitis, in particular, that of the knee and elbow or other joints that are amenable to topical treatment and is recommended for short-term use (4-12 weeks). There is little evidence to utilize topical NSAIDs for treatment of osteoarthritis of the spine, hip or shoulder. The documentation indicates that the patient was approved for oral Ibuprofen 800mg TID. The guidelines indicate that Voltaren Gel is recommended only if the patient is intolerant to oral NSAIDs. For these reasons the request for Voltaren Gel 1% 2 grams #2 is not medically necessary.

**Pennsaid 1.5%:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines topical analgesics Page(s): 111-113. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain(chronic)-Diclofenac, topical (Flector<sup>®</sup>, Pennsaid<sup>®</sup>, Voltaren<sup>®</sup> Gel).

**Decision rationale:** Pennsaid 1.5% is not medically necessary per the MTUS Chronic Pain Medical Treatment Guidelines. The ODG states that Pennsaid is not recommended as a first-line treatment, but recommended as an option for patients at risk of adverse effects from oral NSAIDs. The MTUS states that topical NSAIDs are to be used for osteoarthritis and tendinitis, in particular, that of the knee and elbow or other joints that are amenable to topical treatment and is recommended for short-term use (4-12 weeks). There is little evidence to utilize topical NSAIDs for treatment of osteoarthritis of the spine, hip or shoulder. The documentation indicates that the patient was approved for oral Ibuprofen 800mg TID. The guidelines indicate that Pennsaid is recommended only if the patient is intolerant to oral NSAIDs. The request also does not indicate a quantity. For these reasons the request for Pennsaid is not medically necessary.