

<b>Case Number:</b>	CM14-0083643		
<b>Date Assigned:</b>	08/08/2014	<b>Date of Injury:</b>	07/08/2011
<b>Decision Date:</b>	02/05/2015	<b>UR Denial Date:</b>	05/13/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/05/2014

### 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 Interventional Spine 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 patient is a 48 year old female with an injury date of 07/08/11. According to the 12/16/13 progress report, the patient's back symptoms are mildly improving and she continues to take medication for pain. The 01/28/14 report states that the paravertebral muscles are tender, spasm is present, and range of motion is restricted. In regards to the left knee, joint effusion is noted, the medial aspect of the knee is tender to palpation, and there is a positive McMurray's. On 04/29/14, she continues to experience back and knee pain. No further exam findings were provided. The patient's diagnoses include the following: Lumbar Radiculopathy Left knee internal derangement Left S1 radiculopathy Left ACL tear, chronic The utilization review determination being challenged is dated 05/13/14. Treatment reports were provided from 09/03/13 - 04/29/14. Reports provided were brief.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Hydrocodone/APAP (Norco) 10/325mg #60:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Criteria For Use Of Opioids; Medication for Chronic Pain, Page(s): 88,89, 76-78; 60-61.

**Decision rationale:** Based on the 04/29/14 report, the patient presents with back pain and knee pain. The request is for Hydrocodone/APAP (Norco) 10/325 MG #60. The patient has been taking Hydrocodone/APAP (Norco) as early as 11/14/13. MTUS Guidelines pages 88 and 89 states, "Pain should be assessed at each visit, and functioning should be measured at 6-month intervals using the numerical scale of validated instrument." MTUS page 78 also requires documentation of the 4 A's (analgesia, ADLs, adverse side effects, and adverse behavior), as well as "pain assessment" or outcome measures that include current pain, average pain, least pain, intensity of pain after taking the opioid, time it takes for medication to work and duration of pain relief. The 11/14/13 report states that the patient "continues to take medication for pain which does help her symptoms." The 12/16/13 report indicates that the patient's "back symptoms are mildly improving." No further discussions were provided regarding Hydrocodone/APAP (Norco). In this case, none of the 4 A's were addressed as required by MTUS. The treating physician fails to provide any pain scales. There are no examples of ADLs which demonstrate medication efficacy or are there any discussions provided on adverse behavior/side effects. There are no opiate management issues discussed such as CURES report, pain contracts, etc. No outcome measures are provided either as required by MTUS. In addition, urine drug screen to monitor for medicine compliance are not addressed. The treating physician has failed to provide the minimum requirements of documentation that are outlined in the MTUS for continued opioid use. The requested hydrocodone IS NOT medically necessary.

**Omeprazole DR 20mg #30 with 2 refills:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI Symptoms and Cardiovascular Risk.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI Symptoms & Cardiovascular Risk Page(s): 68-69.

**Decision rationale:** Based on the 04/29/14 report, the patient presents with back pain and knee pain. The request is for Omeprazole DR 20 mg #30; 2 Refills. The patient has been taking Omeprazole as early as 11/14/13. MTUS Guidelines page 68 and 69 state that omeprazole is recommended with precaution for patients at risk for gastrointestinal events: 1.) Ages greater than 65. 2.) History of peptic ulcer disease and GI bleeding or perforation. 3.) Concurrent use of ASA or corticosteroid and/or anticoagulant. 4.) High-dose/multiple NSAID. MTUS page 69 states "NSAIDs, GI symptoms and cardiovascular risk: Treatment of dyspepsia secondary to NSAID therapy: Stop the NSAID, switch to a different NSAID, or consider H2-receptor antagonists or a PPI." The patient is currently taking Hydrocodone, Omeprazole, Orphenadrine, Zolpidem Tartrate, Medrox Pain Relief Ointment, and Naproxen Sodium. In this case, there are no discussions regarding what Omeprazole is doing for the patient. The treating physician does not document dyspepsia or GI issues. Routine prophylactic use of PPI without documentation of gastric issues is not supported by the guidelines without GI-risk assessment. Given the lack of discussion as to this medication's efficacy, and lack of rationale for its use, the requested Omeprazole IS NOT medically necessary.

**Orphenadrine ER 100mg #60:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants (for pain). Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain (chronic)

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants (for pain) Page(s): 63-66.

**Decision rationale:** Based on the 04/29/14 report, the patient presents with back pain and knee pain. The request is for Orphenadrine ER 100 mg #60. MTUS pages 63-66 guidelines do not recommend long-term use of muscle relaxants and recommends using it for 3 to 4 days for acute spasm and no more than 2 to 3 weeks. In this case, the patient's paravertebral muscles are tender, spasm is present, and range of motion is restricted. She has been taking this medication as early as 11/14/13 and it appears as though the patient is using this medication on a long-term basis, which is not within MTUS guidelines. Therefore, the requested Orphenadrine IS NOT medically necessary.

**Zolpidem Tartrate 10mg #30 with 3 refills:** 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), Pain (Acute & Chronic).

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Mental Illness and Stress Chapter, zolpidem (Ambien)

**Decision rationale:** Based on the 04/29/14 report, the patient presents with back pain and knee pain. The request is for Zolpidem Tartrate 10 mg #30; 3 Refills. MTUS and ACOEM Guidelines are silent with regards to this request. However, ODG Guidelines Mental Illness and Stress Chapter, zolpidem (Ambien) state, "Zolpidem (Ambien generic available, Ambien CR) is indicated for short-term treatment of insomnia with difficulty of sleep onset (7-10 days). Ambien CR is indicated for treatment of insomnia with difficulty of sleep onset and/or sleep maintenance. Longer-term studies have found Ambien CR to be effective for up to 24 weeks in adults." Progress reports indicate that the patient has been taking Zolpidem as early as 11/14/13. The patient has been taking Ambien on a long-term basis which is not indicated by ODG Guidelines. ODG Guidelines support only 7 to 10 days of this medication for insomnia. In addition, the patient does not present with insomnia with difficulty of sleep onset as required by ODG Guidelines. Therefore, the requested Zolpidem Tartrate IS NOT medically necessary.

**Medrox pain relief ointment 240 grams #1 with 2 refills:** Upheld

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

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

**Decision rationale:** Based on the 04/29/14 report, the patient presents with back pain and knee pain. The request is for Medrox Pain Relief Ointment 240 grams #1 with 2 Refills. MTUS Guidelines page 111 has the following regarding topical creams, "Topical analgesics are largely experimental and used with few randomized controlled trials to determine efficacy or safety." MTUS further states, "Any compounded product that contains at least one (or drug class) that is not recommended is not recommended." Medrox is a compound topical analgesic that includes methyl salicylate 20%, menthol 7%, and capsaicin 0.050%. MTUS Guidelines allows capsaicin for chronic pain condition such as fibromyalgia, osteoarthritis, and nonspecific low back pain. However, MTUS Guidelines consider doses that are higher than 0.025% to be experimental particularly at high doses. Medrox ointment contains 0.075% of capsaicin, which is not supported by MTUS Guidelines. Therefore, Medrox Pain Relief Ointment IS NOT medically necessary.

**One back support:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 298, 301. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back- Lumbar & Thoracic (Acute & Chronic).

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 301. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, Lumbar Supports

**Decision rationale:** Based on the 04/29/14 report, the patient presents with back pain and knee pain. The request is for One Back Support. ACOEM Guidelines page 301 on lumbar bracing state, "Lumbar supports have not been shown to have any lasting benefit beyond the acute phase of symptom relief." ODG Guidelines under its low back chapter, lumbar supports states, "Prevention: Not recommended for prevention. There is strong and consistent evidence that lumbar supports were not effective in preventing neck and back pain." Under treatment, ODG further states, "Recommended as an option for compression fractures and specific treatment of spondylolisthesis, documented instability, and for treatment of nonspecific LBP (very low-quality evidence, but may be a conservative option)." There was no reason provided for the request. In this case, the patient's paravertebral muscles are tender, spasm is present, and range of motion is restricted. The patient does not present with fracture, spondylolisthesis, or documented instability to warrant lumbar bracing. For nonspecific low back pain, there is very low-quality evidence. The requested back support IS NOT medically necessary.

**One knee brace (wraparound with hidge):** Overturned

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 340.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 304. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee and Leg Chapter under Knee Brace.

**Decision rationale:** Based on the 04/29/14 report, the patient presents with back pain and knee pain. The request is for One Knee Brace (Wrap around with Hinge). The rationale is that "the evidenced based guidelines indicate that the use of a knee brace should be combined with an active rehabilitation program and as per the submitted documentation, it does not appear as though the patient is engaged in an active rehabilitation program at this time." ACOEM page 304 recommends "knee brace for patellar instability, anterior cruciate ligament (ACL) tear, or medical collateral ligament (MCL) instability although its benefits may be more emotional (i.e., increasing the patient's confidence) than medical. Usually a brace is necessary only if the patient is going to be stressing the knee under load, such as climbing ladders or carrying boxes. For the average patient, using a brace is usually unnecessary. In all cases, braces need to be properly fitted and combined with a rehabilitation program." ODG, Knee and Leg Chapter under Knee Brace, does recommend knee brace for the following conditions "knee instability, ligament insufficient, reconstructive ligament, articular defect repair as vascular necrosis, meniscal cartilage repair, painful failed total knee arthroplasty, painful high tibial osteotomy, painful unicompartmental OA, or tibial plateau fracture." The treating physician does not provide a reason for the request. Regarding the patient's left knee, there is joint effusion, the medial aspect of the knee is tender to palpation, and there is a positive McMurray's. ACOEM Guidelines support knee brace "for patellar instability, anterior cruciate ligament (ACL) tear, or medical collateral ligament (MCL) instability." In this case, the patient was diagnosed with a chronic left ACL tear and with left knee internal derangement. Therefore the requested knee brace IS medically necessary.