

Case Number:	CM15-0169871		
Date Assigned:	09/10/2015	Date of Injury:	09/13/2012
Decision Date:	10/13/2015	UR Denial Date:	08/04/2015
Priority:	Standard	Application Received:	08/28/2015

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: North Carolina

Certification(s)/Specialty: Family Practice

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 61 year old male, who sustained an industrial injury on September 13, 2012, resulting in pain or injury to the left knee. Currently, the injured worker reports continuous left knee pain. A review of the medical records indicates that the injured worker is undergoing treatment for left knee degenerative joint disease left knee chondromalacia, left knee cruciate ligament sprain-strain, left knee internal derangement, and status post left knee surgery. Per the most recent Primary Treating Physician's progress report submitted dated June 10, 2015, the injured worker rated his left knee pain as an 8 on a scale of 1 to 10, with 1 being the lowest level of pain and 10 being the maximum level of pain. Physical examination was noted to show the injured worker using a left knee brace, with an antalgic gait and a mild limp. The left knee was noted to have tenderness to palpation of the anterior knee with muscle spasm, and positive McMurray's, Anterior Drawer, and Patellar Compression tests. The Physician noted the treatment plan was to include a prescription for Norco and compound creams. The injured worker's work status was noted to be currently working for his per-injury employer, placed on temporary total disability. The only two physical examinations submitted for review, dated January 26, 2015, and June 10, 2015, revealed an increase in the injured worker's level of pain from 3 out of 10 in January to 8 out of 10 in June. The injured worker was noted not to be working in January, returning to work on a modified duty basis, and working as of June. The January 26, 2015, examination noted the injured worker had been "using Norco for a prolonged period of time". On June 10, 2015, the injured worker was noted to be taking medications for hypertension, with Norco prescribed. Prior treatments have included left knee surgeries noted to

have improved the pain with the instability unchanged, physical therapy, left knee bracing, and medication. The request for authorization dated July 28, 2015, requested a pharmacy purchase of Norco 10/325mg QTY: 60, and HMPHCC2-Flurbiprofen 20%-Baclofen 5%-Camphor 2%-Menthol 2%-Dexamethasone Micro 0.2%-Capsaicin 0.025%-Hyaluronic Acid 0.2% in cream base. The Utilization Review (UR) dated August 4, 2015, recommended partial certification of the Norco to #45 to allow the injured worker to be weaned off the medication, and non-certification of HMPHCC2-Flurbiprofen 20%-Baclofen 5%-Camphor 2%-Menthol 2%-Dexamethasone Micro 0.2%-Capsaicin 0.025%-Hyaluronic Acid 0.2% in cream base.

IMR ISSUES, DECISIONS AND RATIONALES

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

Norco 10/325mg qty: 60: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids, criteria for use.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids for chronic pain.

Decision rationale: The California chronic pain medical treatment guidelines section on opioids states for ongoing management: On-Going Management. Actions Should Include: (a) Prescriptions from a single practitioner taken as directed, and all prescriptions from a single pharmacy. (b) The lowest possible dose should be prescribed to improve pain and function. (c) Office: Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. 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. Information from family members or other caregivers should be considered in determining the patient's response to treatment. The 4 A's for Ongoing Monitoring: Four domains have been proposed as most relevant for ongoing monitoring of chronic pain patients on opioids: pain relief, side effects, physical and psychosocial functioning, and the occurrence of any potentially aberrant (or non-adherent) drug-related behaviors. These domains have been summarized as the "4 A's" (analgesia, activities of daily living, adverse side effects, and aberrant drug taking behaviors). The monitoring of these outcomes over time should affect therapeutic decisions and provide a framework for documentation of the clinical use of these controlled drugs. (Passik, 2000) (d) Home: To aid in pain and functioning assessment, the patient should be requested to keep a pain diary that includes entries such as pain triggers, and incidence of end-of-dose pain. It should be emphasized that using this diary will help in tailoring the opioid dose. This should not be a requirement for pain management. (e) Use of drug screening or inpatient treatment with issues of abuse, addiction, or poor pain control. (f) Documentation of misuse of medications (doctor- shopping, uncontrolled drug escalation, drug diversion). (g) Continuing review of overall situation with regard to non-opioid means of pain control. (h) Consideration of a consultation with a multidisciplinary pain clinic if doses of opioids are required beyond what is usually required for the condition or pain does not improve on opioids in 3 months. Consider a psych consult if there is evidence of depression, anxiety or irritability. Consider an addiction medicine consult if there is evidence of substance misuse. When to Continue Opioids: (a) If the patient has returned to work; (b) If the patient has improved functioning and pain. (Washington, 2002) (Colorado, 2002) (Ontario, 2000) (VA/DoD, 2003)

(Maddox-AAPM/APS, 1997) (Wisconsin, 2004) (Warfield, 2004) The long-term use of this medication class is not recommended per the California MTUS unless there documented evidence of benefit with measurable outcome measures and improvement in function. These criteria have been met in the provided documents and the request is medically necessary.

HMPHCC2 - Flurbiprofen 20%/Baclofen 5%/Camphor 2%/Menthol 2%/Dexamethasone Micro 0.2%/Capsaicin 0.025%/Hyaluronic Acid 0.2% in cream base: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Topical Analgesics.

Decision rationale: The California chronic pain medical treatment guidelines section on topical analgesics states: Recommended as an option as indicated below. Largely experimental in use with few randomized controlled trials to determine efficacy or safety. Primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. (Namaka, 2004) These agents are applied locally to painful areas with advantages that include lack of systemic side effects, absence of drug interactions, and no need to titrate. (Colombo, 2006) Many agents are compounded as monotherapy or in combination for pain control (including NSAIDs, opioids, capsaicin, local anesthetics, antidepressants, glutamate receptor antagonists, adrenergic receptor agonist, adenosine, cannabinoids, cholinergic receptor agonists, agonists, prostanoids, bradykinin, adenosine triphosphate, biogenic amines, and nerve growth factor). (Argoff, 2006) There is little to no research to support the use of many of these agents. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. The requested medication contains ingredients, which are not indicated per the California MTUS for topical analgesic use. Therefore, the request is not medically necessary.