

Case Number:	CM15-0032536		
Date Assigned:	02/26/2015	Date of Injury:	04/29/2014
Decision Date:	07/09/2015	UR Denial Date:	02/05/2015
Priority:	Standard	Application Received:	02/20/2015

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: Colorado

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 31 year old male who sustained an industrial injury on 04/29/2014 when an ATM machine fell hitting his left knee and leg. The injured worker was diagnosed with left knee internal derangement, anxiety and depression. Treatment to date includes diagnostic testing, conservative measures, acupuncture therapy, chiropractic therapy, psychological pain evaluation and medications. Magnetic resonance arthrogram (MRA) performed on December 29, 2014 was reported as Grade III tear involving the body and posterior horn of the medial meniscus, degenerative arthritis with reduced joint space, chondromalacia and osteophyte and a subchondral cyst at the posterior aspect of the lateral femoral condyle. According to the primary treating physician's progress report on January 13, 2015, the injured worker continues to experience stiffness and weakness of the left knee. The injured worker rates his pain level at 7/10. Examination demonstrated mild swelling at the left knee with tenderness to palpation of the anterior knee, lateral and medial joint line and superior border of the patella. There was muscle spasm present at the anterior and posterior knee. McMurray's caused pain. The injured worker had a slight antalgic gait. Current medications are listed as Norco, Naproxen and Pantoprazole. Treatment plan consists of physical therapy and acupuncture therapy to increase range of motion and decrease pain and spasm, follow-up with orthopedic surgeon for possible invasive treatment, use of a cane for ambulation and continue with medication regimen and the current request for Compound GCB- Gabapentin 10%/Cyclobenzaprine6%/Bupivacaine 5% in cream base, Compound FBD-Flurbiprofen 20%/Baclofen 5%/Dexamethasone 2%/Camphor 2% Capsaicin 0.025% in cream base, Compound GAB-Gabapentin 10% Amitriptyline 10%/Bupivacaine 5% in cream base 240 grams, Norco tabs 10-325mg #100 tablets for

purposes of tapering and Pantoprazole.

IMR ISSUES, DECISIONS AND RATIONALES

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

Compound GCB- Gabapentin 10%/ Cyclobenzaprine 6%/ Bupivacaine 5% in cream base:
Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics page(s): 112.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Pain Interventions and Treatments page(s): 111-113.

Decision rationale: Per the MTUS Guidelines, topical analgesics may be indicated for specific conditions when other therapies have failed. However, the guidelines make it clear that if a drug or drug class in a given topical compound is "not recommended," then the entire compounded topical is not recommended. The requested topical analgesics include Gabapentin/ Cyclobenzaprine/Bupivacaine Topical muscle relaxers, including Cyclobenzaprine, are not recommended, per the guidelines and have no evidence-based support for their use. topical preparations. The MTUS Guidelines do not address topical Bupivacaine, which in this case is not relevant because the Gabapentin and Cyclobenzaprine are not recommended, so the entire topical preparation is not recommended and not medically indicated.

Pantoprazole Tab 20mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk page(s): 68. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Proton pump inhibitors.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Pain Interventions and Treatments page(s): 68.

Decision rationale: Per the Guidelines, a patient at intermediate risk for gastrointestinal event, but at no risk from cardiovascular event, would need a non-selective non-steroidal anti-inflammatory drug, and Proton Pump Inhibitor to protect stomach. Non-steroidal anti-inflammatory drugs do carry risks of gastrointestinal symptoms and cardiovascular and renal effects. The following questions should be taken into consideration when providing non-steroidal anti-inflammatory drugs for pain patients: (1) age > 65 years; (2) history of peptic ulcer, GI bleeding or perforation; (3) concurrent use of ASA, corticosteroids, and/or an anticoagulant; or (4) high dose/multiple NSAID (e.g., NSAID + low-dose ASA). Per the records for the patient of concern, the issue of gastrointestinal events was not addressed in the clinic notes. There is no documentation of previous or ongoing diagnosis that would increase risk of gastrointestinal events. (No known peptic ulcer disease or bleed) He would not meet the above criteria for proton pump inhibitor addition to non-steroidal anti-inflammatory drug use. The most recent clinic record available is from January 2015, so current medications

unknown. Furthermore, as it is not clear from the record if patient even still takes non-steroidal anti-inflammatory drug, the protective proton pump inhibitor, Protonix, would not be medically necessary.

Compound GAB-Gabpentin 10% Amitriptyline 10%/Bupivacaine 5% in cream base 240 grams: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics page(s): 112.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Pain Interventions and Treatments page(s): 111-113.

Decision rationale: Per the MTUS Guidelines, topical analgesics may be indicated for specific conditions when other therapies have failed. However, the guidelines make it clear that if a drug or drug class in a given topical compound is "not recommended," then the entire compounded topical is not recommended. The requested topical analgesics include Gabapentin/Amytriptyline/Bupivacaine. Per the MTUS Guidelines, Gabapentin topical is not recommended. No studies support its use in topical preparations. The MTUS Guidelines do not address topical Amytriptyline or Bupivacaine, which in this case is not relevant because the Gabapentin is not recommended, so the entire topical preparation is not recommended and not medically indicated.

Norco tabs 10-325mg #100 tablets for purposes of taper for discontinuation over the course of the next 2-3 months: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids page(s): 43, 74, 76-78, 80, 86, 91 & 124.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Pain Interventions and Treatments page(s): 79-80, 85, 88-89, and 91.

Decision rationale: The Guidelines establish criteria for use of opioids, including long term use (6 months or more). When managing patients using long term opioids, the following should be addressed: Re-assess the diagnosis and review previous treatments and whether or not they were helpful. When re-assessing, pain levels and improvement in function should be documented. Pain levels should be documented every visit. Function should be evaluated every 6 months using a validated tool. Adverse effects, including hyperalgesia, should also be addressed each visit. Patient's motivation and attitudes about pain/work/interpersonal relationships can be examined to determine if patient requires psychological evaluation as well. Aberrant/addictive behavior should be addressed if present. Do not decrease dose if effective. Medication for breakthrough pain may be helpful in limiting overall medication. Follow up evaluations are recommended every 1-6 months. To summarize the above, the 4As of Drug Monitoring (analgesia, activities of daily living, adverse side effects, and aberrant drug-taking Behaviors) have been established. 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) Several circumstances need to be considered when determining to discontinue opioids: 1) Verify patient has not had failure to improve because of inappropriate dosing or under-dosing of opioids 2) Consider possible reasons for immediate discontinuation including diversion, prescription forgery, illicit drug use, suicide attempt, arrest related to opioids, and aggressive or threatening behavior in clinic. Weaning from the medication over 30 day period, under direct medical supervision, is recommended unless a reason for immediate discontinuation exists. If a medication contract is in place, some physicians will allow one infraction without immediate discontinuation, but the contract and clinic policy should be reviewed with patient and consequences of further violations made clear to patient 3) consider discontinuation if there has been no improvement in overall function, or a decrease in function 4) patient has evidence of unacceptable side effects 5) patient's pain has resolved 6) patient exhibits "serious non-adherence." Per the Guidelines, Chelminski defines "serious substance misuse" or non-adherence as meeting any of the following criteria: (a) cocaine or amphetamines on urine toxicology screen (positive cannabinoid was not considered serious substance abuse); (b) procurement of opioids from more than one provider on a regular basis; (c) diversion of opioids; (d) urine toxicology screen negative for prescribed drugs on at least two occasions (an indicator of possible diversion); & (e) urine toxicology screen positive on at least two occasions for opioids not routinely prescribed. (Chelminski, 2005) 7) Patient requests discontinuing opioids 8) consider verifying that patient is in consultation with physician specializing in addiction to consider detoxification if patient continues to violate the medication contract or shows other signs of abuse / addiction 9) document the basis for decision to discontinue opioids. Likewise, when making the decision to continue opioids long term, consider the following: Has patient returned to work" Has patient had improved function and decreased pain with the opioids." Per the records supplied for review, the patient of concern continues to rank pain at 9-10/10 despite treatments which include Norco. The most recent clinic note supplied is from January 2015, and there is no mention of tapering or discontinuing Norco, so not clear as to the reasons for taper. No schedule is supplied for the taper. As above, the records do not establish objective evidence of improved function with Norco, and in fact the records do show that pain is not consistently improved on the Norco, rated 9-10/10. Without updated documentation specifying patient condition and the reasons / plan for tapering Norco, and as Norco has not, based on the records helped pain or function over time, the Norco is not medically indicated for patient

Compound FBD-Flurbiprofen 20%/Baclofen 5%/ Dexamethasone 2%/Camphor 2% Capsaicin 0.025% in cream base: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics page(s): 112.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Pain Interventions and Treatments page(s): 111-113.

Decision rationale: Per the MTUS Guidelines, topical analgesics may be indicated for specific conditions when other therapies have failed. However, the guidelines make it clear that if a drug or drug class in a given topical compound is "not recommended," then the entire compounded

topical is not recommended. The requested topical analgesics include Flurbiprofen/Baclofen/Dexamethasone Topical Baclofen and other Topical muscle relaxers are not recommended, per the guidelines and have no evidence-based support for their use-numbers, so no substantive evidence supports long term use. Use of topical non-steroidal anti-inflammatory drugs can be recommended for less than 12 weeks, for treatment of osteoarthritis, specifically related to the knee or elbow. No consistent quality evidence exists to use topical non-steroidal anti-inflammatory drugs for treatment of osteoarthritis of the spine, hip or shoulder, or for treatment of Neuropathic Pain. The only FDA-approved Topical Non-steroidal anti-inflammatory agent is Voltaren[®] Gel 1% (diclofenac). The MTUS Guidelines do not address topical Dexamethasone, which in this case is not relevant because the Baclofen, is not recommended and the Flurbiprofen is not FDA approved for topical use, so the entire topical preparation is not recommended and not medically indicated.