

Case Number:	CM14-0115061		
Date Assigned:	08/06/2014	Date of Injury:	05/13/2009
Decision Date:	10/07/2014	UR Denial Date:	06/24/2014
Priority:	Standard	Application Received:	07/23/2014

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 Illinois. 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 injured worker is a 56-year-old male who reported an injury on 05/13/2008. The mechanism of injury was from repetitive movements. The diagnosed included work related injury lumbar spine, degenerative disc disease, bilateral mensical tears, degenerative joint disease both knees. The previous treatments included medication and physical therapy. The diagnostic testing included an MRI. Within the clinical note dated 05/08/2014, it was reported the injured worker complained of left and right knee pain. The injured worker reported the left knee pain was constant. He rated his pain for his left knee 6/10 to 7/10 in severity. The injured worker complained of right knee pain which he rated 6.5/10 in severity. Upon the physical examination, the provider noted the injured worker was unable to perform an examination of the knees due to pain. The provider requested Hydrocodone, Naproxen, Xolindo topical analgesic, Terocin, Flurbi(NAP) cream, Gabacyclotram, Somnicin, Melatonin, Tryptophan, and TENS unit, all for pain. However, the request for authorization was not submitted for clinical review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Hydrocodone/acetaminophen 10/325mg #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Hydrocodone/acetaminophen Page(s): 91.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines OPIOIDS, CRITERIA FOR USE, ON-GOING MANAGEMENT Page(s): 78.

Decision rationale: The request for Hydrocodone/Acetaminophen 10/325 #90 is not medically necessary. The California MTUS Guidelines recommend ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. The guidelines recommend the use of urine drug screen or inpatient treatment with issues of abuse, addiction, or poor pain control. There was a lack of documentation indicating the efficacy of the medication as evidenced by significant functional improvement. The request submitted failed to provide the frequency of the medication. The provider failed to document an adequate and complete pain assessment within the documentation. The request as submitted failed to provide the frequency of the medication. Therefore, the request is not medically necessary.

Naproxen 550mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): 67, 68, 73.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NAPROXEN Page(s): 66-67.

Decision rationale: The request for naproxen 550 mg is not medically necessary. The California MTUS Guidelines note Naproxen is a nonsteroidal anti-inflammatory for the relief and signs and symptoms of osteoarthritis. The guidelines recommend naproxen for the lowest dose for the shortest period of time. There was a lack of documentation indicating the efficacy of the medication as evidenced by significant functional improvement. The request submitted failed to provide the frequency for the medication. Therefore, the request is not medically necessary.

Xolindo 2% topical analgesic cream: Upheld

Claims Administrator 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 (updated 06/10/2014) Compound drugs

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TOPICAL NSAIDS Page(s): 111-112.

Decision rationale: The request for Xolindo 2% topical analgesic cream is not medically necessary. The California MTUS Guidelines recommend topical NSAIDs for osteoarthritis and tendinitis, in particular that of the knee and/elbow, and other joints that are amenable. Topical NSAIDs are recommended for short-term use of 4 to 12 weeks. There was a lack of documentation indicating the efficacy of the medication as evidenced by significant functional improvement. The request submitted failed to provide the treatment site. The request submitted failed to provide the frequency of the medication. Therefore, the request is not medically necessary.

Terocin 120ml: Capsaicin 0.025%-Menthyl salicylate 25%-Menthol 10%-lidocaine 2.5%:
Upheld

Claims Administrator 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 (updated 06/10/2014) Compound drugs

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TOPICAL NSAIDS Page(s): 111-112.

Decision rationale: The request for Terocin 120 ml, capsaicin 0.025%, Menthyl Salicylate 25%, Menthol 10%, Lidocaine 2.5% is not medically necessary. The California MTUS Guidelines note topical NSAIDs are recommended for the use of osteoarthritis and tendinitis, in particular that of the knee and/elbow, and other joints that are amenable. Topical NSAIDs are recommended for short term use of 4 to 12 weeks. The guidelines note capsaicin is only recommended in patients who do not respond or are intolerant to other treatments. Lidocaine is recommended for localized peripheral pain after there has been evidence of a trial of first line therapy. Topical Lidocaine in the formulation of a dermal patch, Lidoderm, has been designated for orphan status by the FDA for neuropathic pain. Lidoderm is also used off label for diabetic neuropathy. There was a lack of documentation indicating the efficacy of the medication as evidenced by significant functional improvement. The request submitted failed to provide the frequency of the medication. Therefore, the request is not medically necessary.

Flurbi(NAP) cream-LA 180gms: Flurbiprofen 20%-Lidocaine 5%-Amitriptyline 4%:
Upheld

Claims Administrator 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 (updated 06/10/2014) Compound drugs

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TOPICAL NSAIDS Page(s): 72, 111-112.

Decision rationale: The request for Flurbiprofen cream LA 180gms, Flurbiprofen 20%, Lidocaine 5%, Amitriptyline 4% is not medically necessary. The California MTUS Guidelines recommend topical NSAIDs for the use of osteoarthritis and tendinitis, in particular that of the knee and/elbow, and other joints that are amenable. Topical NSAIDs are recommended for short term use of 4 to 12 weeks. Flurbiprofen is recommended for osteoarthritis and mild to moderate pain. Lidocaine is recommended for localized peripheral pain after there has been evidence of a trial of first line therapy. There was a lack of documentation indicating the efficacy of the medication as evidenced by significant functional improvement. The request submitted failed to provide the frequency of the medication. Therefore, the request is not medically necessary.

Gabaclotram 180gms: Gabapentin 10%-Cyclobenzaprine 6%-Tramadol 10%: Upheld

Claims Administrator 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 (updated 06/10/2014) Compound drugs

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TOPICAL NSAIDS Page(s): 111-112.

Decision rationale: The request for Gabacyclotram 180gms: Gabapentin 10%, Cyclobenzaprine 6%, Tramadol 10% is not medically necessary. The California MTUS Guidelines note topical NSAIDs for use in osteoarthritis and tendinitis, in particular that of the knee and/elbow, and other joints that are amenable. Topical NSAIDs are recommended for short term use of 4 to 12 weeks. The guidelines notes Gabapentin is not recommended for topical use. There was a lack of documentation indicating the efficacy of the medication as evidenced by significant functional improvement. The request submitted failed to provide the frequency of the medication. The request submitted failed to provide the treatment site. Therefore, the request is not medically necessary.

Somnicin #30 capsules: Melatonin 2mg-5HTP 50mg-L tryptophan 100mg-Pyridoxine 10mg-Magnesium 50mg: 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 (updated 06/10/2014); <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2908021/JournalListIntJTryptophanresv.2;2009PMC2908021>

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TOPICAL NSAIDS Page(s): 111-112.

Decision rationale: The request for Somnicin #30 capsules: melatonin 2mg, 5HTP 50mg, L Tryptophan 100mg, Pyridoxine 10mg, and Magnesium 50mg is not medically necessary. The California MTUS Guidelines note topical NSAIDs are recommended for osteoarthritis and tendinitis, in particular that of the knee and/elbow, and other joints that are amenable. There was a lack of documentation indicating the efficacy of the medication as evidenced by significant functional improvement. The request submitted failed to provide the frequency if medication. Therefore, the request is not medically necessary.

TENS unit and supplies for thirty (30) day trial: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrotherapy Page(s): 116.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TRANSCUTANEOUS ELECTROTHERAPY Page(s): 114-116.

Decision rationale: The request for a TENS unit and supplies for a 30 day trial is not medically necessary. The California MTUS Guidelines do not recommend a TENS unit as a primary treatment modality. A 1 month home based TENS trial may be considered as a noninvasive conservative option. If used as an adjunct to a program of evidence based functional restoration. There is evidence that other appropriate pain modalities have been tried, including medication, and failed. There was a lack of documentation indicating significant functional deficits upon the physical examination. There was a lack of documentation indicating the failure of conservative treatment. The request submitted failed to indicate whether the provider was requesting the request TENS unit for rental or purchase. Therefore, the request is not medically necessary.