

Case Number:	CM14-0115749		
Date Assigned:	09/24/2014	Date of Injury:	01/22/2010
Decision Date:	10/27/2014	UR Denial Date:	06/26/2014
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 Occupational Medicine 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:

65 year old male store clerk/stocker who injured his right knee at work 10 Jan 2010 and since developed chronic pain-related insomnia. His present diagnoses are: 1) Right knee internal derangement/status post arthroscopic medial and lateral meniscectomy (23 Apr 2010)/status post total knee replacement (28 Jun 2011), 2) Right knee pain and 3) Chronic insomnia. His right knee began buckling in May 2012. In June 2014 he fell when his right knee gave out while walking causing an exacerbation of the knee pain and injury to his left hip. This caused pain at level 9/10 that reduces to 5/10 with medication. MRI of the hip a week or 2 after the injury (26 Jun 2013) revealed microtrabecular fracture of the anterior wall of the left acetabulum with extensive bone marrow edema and a full thickness chondral tear of left side of acetabulum. Other Xrays and Scans: Right knee xray Feb 2010 was normal. MRI of right knee (1 Mar 2010) showed medial meniscus tear and a bone bruise of medial femoral condyle. MRI of right knee (Sep 2010) showed subchondral flattening (osteonecrosis) in area of prior bone bruise. MRI (Feb 2011) showed similar osteonecrosis. Xray right knee (Mar 2013) showed on fracture and status post right knee replacement. Present medications are: Trepadone, Gabadone, Nattokinase, Norco 10/325 mg (Begun 8 Dec 2011), Clonidine 0.1 mg (Begun 20 Mar 2014), Fluriflex ointment and Toradol IM. Past therapy and medications included: Norco (10/325 started 1 Feb 2010, restarted after knee replacement 8 Dec 2011), Naprosyn, Flexeril, Lodine, Ultracet, nortriptyline, ibuprofen, Celebrex, Oxycontin, Vimovo, Ambien, Euflexxa (Joint injection), Depomedrol/Marcaine (joint injection), Physical therapy (twice), ice and heat packs, knee brace.

IMR ISSUES, DECISIONS AND RATIONALES

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

Norco 10/325mg #120: Overturned

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment Page(s): 49, Chronic Pain Treatment Guidelines (CPMTG) Part 2 Page(s): 60, 74-96.

Decision rationale: Norco is a mixed medication made up of the opioid, hydrocodone, and acetaminophen, better known as Tylenol. It is recommended for moderate to moderately severe pain with usual dosing of 5-10 mg hydrocodone per 325 mg of acetaminophen taken as 1-2 tablets every 4-6 hours. Maximum dose according to the MTUS is limited to 4 gm of acetaminophen per day which is usually 60mg/day of hydrocodone. According to the MTUS opioid therapy for control of chronic pain, while not considered first line therapy, is considered a viable alternative when other modalities have been tried and failed. Success of this therapy is noted when there is significant improvement in pain or function. The risk with this therapy is the development of addiction. The pain guidelines in the MTUS directly address this issue and have a number of recommendations to identify when addiction develops and to prevent addiction from occurring. The present provider is appropriately monitoring this patient and notes the improvement in pain control with the use of opioid preparations. The records also document stability in dosing, in that the same dose of opioid the patient was started on in Dec 2011 is still in present use. Since the patient is not displaying signs of addiction, the medication is effective in lowering the patient's pain and the patient is being appropriately monitored by the treating provider, chronic use of opioids in this instance is not contraindicated. Therefore, Norco 10/325mg #120 is medically necessary and appropriate.

Clonidine 0.1mg #60: Overturned

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Part 2, Page(s): 34-35, 109-110. Decision based on Non-MTUS Citation Lipman AG. Analgesic drugs for neuropathic and sympathetically maintained pain. Clin Geriatr Med 1996;12:501-15. Mohamed SA, Abdel-Ghaffar HS. Effect of the addition of clonidine to locally administered bupivacaine on acute and chronic postmastectomy pain. J Clin Anesth 2013;25:20-7. Davis KD, Treede RD, Raja SN, Meyer RA, Campbell JN. Topical application of clonidine relieves hyperalgesia in patients with sympathetically maintained pain. Pain 1991;47:309-17

Decision rationale: Clonidine is a centrally acting active alpha 2 adrenergic agonist indicated for the control of hypertension, attention-deficit/hyperactivity disorder, anxiety disorders, withdrawal (from either alcohol, opioids, or smoking), migraine and menopausal flushing. However, there is good clinical evidence that supports effectiveness of this medication in chronic pain conditions particularly where neuropathy is a significant component such as chronic post-surgical pain. The patient definitely has chronic post-surgical pain and use of this medication

coupled with treatment with an opioid has shown improved pain control. Therefore, Clonidine 0.1mg #60 is medically necessary and appropriate.