

<b>Case Number:</b>	CM14-0117528		
<b>Date Assigned:</b>	08/06/2014	<b>Date of Injury:</b>	11/20/2009
<b>Decision Date:</b>	10/08/2014	<b>UR Denial Date:</b>	07/09/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/25/2014

### 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, has a subspecialty in Pain Management 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 injured worker is a 27-year-old female who reported an injury on 11/20/2009. The mechanism of injury was not submitted in review. The injured worker has diagnoses of bursitis not elsewhere classified and internal derangement of the knee not otherwise specified. Past medical treatment consists of physical therapy, aquatic therapy, a home exercise program, and medication therapy. Medications include Ketoprofen, Omeprazole, Hydrocodone, and Orphenadrine. On 04/16/2012, the injured worker underwent an MRI of the knee. On 05/15/2014, the injured worker complained of right knee pain. Physical examination revealed superior pole of the patella was tender to palpation. Inferior medial aspect of the knee was tender to palpation over the pes anserine bursa. Examination of the right hip revealed that the greater trochanter was tender to palpation, with limited range of motion. The treatment plan was for the injured worker to continue the use of Hydrocodone and Ketoprofen. The rationale and Request for Authorization form were not submitted for review.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Hydrocodone/APAP 5-325mg Day Supply: 30 Qty:60 Refills: 00: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for Use of Opioids, Therapeutic Trial of Opioids Page(s):.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids (Hydrocodone/APAP) Page(s): 78, 98.

**Decision rationale:** The request for Hydrocodone/APAP 5/325 is not medically necessary. The California Medical Treatment Utilization Schedule (MTUS) Guidelines state the usual dose is 5/500 mg, 1 or 2 tablets by mouth every 4 to 6 hours as needed for pain, with a max of 8 tablets a day. The guidelines also state that prescription should be from a single practitioner taken as directed, and all prescriptions from a single pharmacy. The lowest possible dose should be prescribed to improve pain and function. The MTUS also states that there should be an ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. Pain assessments should include current pain, the least reported pain over the period since last assessment, average pain, and intensity of pain after taking the opioid, how long it takes for pain relief, and how long the 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. The use of drug screening or inpatient treatment with issues of abuse, addiction, or poor pain control is recommended. There were no side effects listed in the submitted reports. Furthermore, there was no evidence that the Hydrocodone/APAP was helping with any functional deficits the injured worker had. Additionally, there was no indication of the injured worker being given any urine drug screens or inpatient treatment. There was also no assessment of the injured worker's pain rates before, during, and after medication with VAS. The request as submitted did not specify a frequency or duration of the medication. Given the above, the injured worker is not within the MTUS recommended guidelines. As such, the request for Hydrocodone/APAP is not medically necessary.

**Ketoprofen Cap 75 MG Day Supply: 30 Qty: 60 Refills: 2: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Ketoprofen Page(s): 67, 70.

**Decision rationale:** The request for Ketoprofen 75 mg is not medically necessary. The California MTUS Guidelines recommend the use of NSAIDs for patients with osteoarthritis (including knee and hip) and patients with acute exacerbations of chronic low back pain. The guidelines also recommend NSAIDs at the lowest dose for the shortest period of time in patients with moderate to severe pain. Acetaminophen may be considered for initial therapy for patients with mild to moderate pain, and in particular, for those with gastrointestinal, cardiovascular, or renovascular risk factors. In patients with acute exacerbations of chronic low back pain, the guidelines recommend NSAIDs as an option for short-term symptomatic relief. NSAIDs are considered the traditional first line of treatment, to reduce pain so activity and functional restoration can resume, but long-term use may not be warranted. The submitted documentation indicates the injured worker was prescribed Ketoprofen since at least 02/2014. Furthermore, the request as submitted is for Ketoprofen 75 mg with a quantity of 60, exceeding the recommended guidelines for short-term use. Given the above, the injured worker is not within the MTUS recommended guidelines. As such, the request is not medically necessary.

**Orphenadrine ER 100 MG Day Supply: 30 Qty: 60 Refills: 2: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain), (Orphenadrine) Page(s): 63-65.

**Decision rationale:** The request for Orphenadrine ER 100mg Day Supply 30 QTY#60 Refills 2 is not medically necessary. According to the California MTUS, Orphenadrine is a non-sedating recommended muscle relaxant with caution as a secondary line option for short term treatment of acute exacerbations in patients with chronic lower back pain. Muscle relaxants may be effective in reducing pain and muscle tension, and increasing mobility. However, in lower back cases, they show no benefit beyond NSAIDs in pain and overall improvement. Also there is no additional benefit shown in combination with NSAIDs. Efficacy appears to diminish over time and prolonged use of some medications in this class may lead to dependence. Sedation is the most commonly reported adverse effect of muscle relaxant medications. Orphenadrine is similar to diphenhydramine, but has greater anticholinergic effects. The mode of action is not clearly understood. Effects are thought to be secondary to analgesic and anticholinergic properties. The request as submitted did not specify a frequency and duration of the medication. There was also no quantified information regarding pain relief. Additionally, the report lacked evidence as to whether the above medication helped the injured worker with any functional deficits. There was no assessment regarding current pain on a VAS, average pain, intensity of pain or longevity of pain relief. In addition, there was no mention of a lack of side effects. Furthermore, the submitted report lacked pertinent information regarding how long the medication had been in use for to date. Given the above, the request for Orphenadrine is not supported by the California MTUS Guideline recommendations. As such, the request for Orphenadrine ER 100mg Day Supply 30 QTY 60 Refills 2 is not medically necessary.