

Case Number:	CM14-0146169		
Date Assigned:	09/15/2014	Date of Injury:	05/24/2010
Decision Date:	10/16/2014	UR Denial Date:	08/19/2014
Priority:	Standard	Application Received:	09/09/2014

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 and 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:

This is a patient with a date of injury of 5/24/10. A utilization review determination dated 8/19/14 recommends non-certification of Orphenadrine/caffeine, gabapentin/pyridoxine, omeprazole/flurbiprofen, hydrocodone/APAP/Ondansetron, topical compounded medications, and a steroid injection with ultrasound guidance. It referenced an undated PR-2 and a medical report dated 8/14/14 noting bilateral knees painful. On exam, there is swelling with limited ROM. X-rays noted no increase of OA. Recommendation was to proceed with right TKA and a US guided cortisone injection was administered to the right knee. A UDS dated 6/10/14 was noted to be negative.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 prescription for Orphenadrine/caffeine 50/10mg #60: Upheld

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 8 C.C.R. 9792.20 - 9792.26 MTUS (Effective July 18, 2009) Page(s): 63-66 of 127.

Decision rationale: Regarding the request for Orphenadrine/caffeine, Chronic Pain Medical Treatment Guidelines support the use of non-sedating muscle relaxants to be used with caution

as a 2nd line option for the short-term treatment of acute exacerbations of pain. Within the documentation available for review, there is no identification of a specific analgesic benefit or objective functional improvement as a result of the medication. Additionally, it does not appear that this medication is being prescribed for the short-term treatment of an acute exacerbation, as recommended by the CA MTUS. Furthermore, no clear rationale is presented identifying the medical necessity of the compound medication rather than the FDA-approved version. In light of the above issues, the currently requested Orphenadrine/caffeine is not medically necessary.

1 prescription of Gabapentin/ pyridoxine 250mg/ 10mg #60: Upheld

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 8 C.C.R. 9792.20 - 9792.26 MTUS (Effective July 18, 2009) Page(s): 16-21 of 127.

Decision rationale: Regarding request for gabapentin/pyridoxine, Chronic Pain Medical Treatment Guidelines state that anti-epilepsy drugs are recommended for neuropathic pain. They go on to state that a good outcome is defined as 50% reduction in pain and a moderate response is defined as 30% reduction in pain. Guidelines go on to state that after initiation of treatment, there should be documentation of pain relief and improvement in function as well as documentation of side effects incurred with use. The continued use of AEDs depends on improved outcomes versus tolerability of adverse effects. Within the documentation available for review, there is no identification of any specific analgesic benefit (in terms of percent reduction in pain or reduction of NRS) and objective functional improvement. Additionally, there is no discussion regarding side effects from this medication. Furthermore, no clear rationale is presented identifying the medical necessity of the compound medication rather than the FDA-approved version. In light of the above issues, the currently requested gabapentin/pyridoxine is not medically necessary.

1 prescription for Hydrocodone/APAP/ondan 10/300/2mg #40 (Vicosetron): Upheld

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 8 C.C.R. 9792.20 - 9792.26 MTUS (Effective July 18, 2009) Page(s): 76-79, 120 of 127. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter Antiemetics (for opioid nausea)

Decision rationale: Regarding the request for Vicosetron, California Pain Medical Treatment Guidelines state that, with regard to opioids, due to high abuse potential, close follow-up is recommended with documentation of analgesic effect, objective functional improvement, side effects, and discussion regarding any aberrant use. Guidelines go on to recommend discontinuing opioids if there is no documentation of improved function and pain. ODG notes that antiemetics are not recommended for nausea and vomiting secondary to chronic opioid use. Within the

documentation available for review, there is no indication that the medication is improving the patient's function or pain (in terms of specific examples of functional improvement and percent reduction in pain or reduced NRS), no documentation regarding side effects, and no discussion regarding aberrant use. There is also no clear indication for the addition of an antiemetic or a rationale for the use of a compound medication rather than the FDA-approved versions of these medications. Given all of the above, there is no clear indication for ongoing use of the medication. Opioids should not be abruptly discontinued, but unfortunately, there is no provision to modify the current request to allow tapering. In light of the above issues, the currently requested Vicosetron is not medically necessary.

1 prescription for flurbiprofen/ cyclo/menth cream 20%/10%/4% #180gm: Upheld

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 8 C.C.R. 9792.20 - 9792.26 MTUS (Effective July 18, 2009) Page(s): 111-113 of 127.

Decision rationale: Regarding the request for flurbiprofen/cyclo/menth cream, CA MTUS states that topical NSAIDs are indicated for "Osteoarthritis and tendinitis, in particular, that of the knee and elbow or other joints that are amenable to topical treatment: Recommended for short-term use (4-12 weeks). There is little evidence to utilize topical NSAIDs for treatment of osteoarthritis of the spine, hip or shoulder. Neuropathic pain: Not recommended as there is no evidence to support use." Muscle relaxants are not supported by the CA MTUS for topical use. Within the documentation available for review, none of the abovementioned criteria have been documented. Furthermore, there is no clear rationale for the use of topical medications rather than the FDA-approved oral forms for this patient. In light of the above issues, the currently requested flurbiprofen/cyclo/menth cream is not medically necessary.

US guided cortisone to (R) knee (retrospective): Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 339. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Knee and Leg Chapter, Corticosteroid injections

Decision rationale: Regarding the request for a US guided cortisone injection to right knee, CA MTUS and ACOEM note that invasive techniques, such as cortisone injections, are not routinely indicated for the knee. ODG states that they are supported for documented symptomatic severe osteoarthritis of the knee when pain is not controlled adequately by recommended conservative treatments and interferes with functional activities. However, they also note that these are generally performed without fluoroscopic or ultrasound guidance. Within the documentation available for review, it appears that the patient has significant OA of the knee and is awaiting a total knee arthroplasty; however, there is no rationale provided identifying the medical necessity

of performing the injection with ultrasound guidance and, unfortunately, there is no provision for modification of the current request. In the absence of such documentation, the currently requested US guided cortisone injection to right knee is not medically necessary.