

<b>Case Number:</b>	CM15-0009058		
<b>Date Assigned:</b>	01/30/2015	<b>Date of Injury:</b>	10/08/2014
<b>Decision Date:</b>	03/27/2015	<b>UR Denial Date:</b>	12/23/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/15/2015

### 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: New York

Certification(s)/Specialty: Anesthesiology

### 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 (IW) is a 33 year old female who sustained an industrial injury on 10/08/2014. She has reported pain in the lumbar spine, right thigh and behind the patella. Diagnoses include chondromalacia of patella, right knee synovitis and tenosynovitis. Treatment and diagnostics to date includes pain medications, a knee brace, chiropractic care, a MRI, x-rays of the right knee and urine drug screening. In a progress note dated 12/13/2014 the treating provider reports right quadriceps tenderness and positive patellar grind. The provider requests chiropractic care with shock wave to the right knee, a brace for the right knee, oral and topical medications, and acupuncture. The IW is to remain off work until released. On 12/23/2014 Utilization Review non-certified a request for Acupuncture 1X4 Right Knee, noting there is no clear documentation of the rationale for providing concurrent physical modalities. The Acupuncture Medical Treatment guidelines Official Medical Fee Schedule (OMFS) were cited. On 12/23/2014 Utilization Review non-certified a request for a Right Knee Patella Brace noting there was no documentation of a condition /diagnosis that supports use of a knee brace. The Official Disability Guidelines (ODG) was cited. On 12/23/2014 Utilization Review non-certified a request for Chiropractic Treatment 2X4 to the right knee, noting with the medical information available for review, there is no documentation of objective functional deficits and functional goals, however, the requested number of chiropractic treatments exceeds guidelines (for an initial trial), therefore certification of the requested Chiropractic treatment 2x4 is modified and certification is recommended for Chiropractic treatment x6 right knee. Certification is not recommended for the remaining Chiropractic treatment x2 of right knee (of the requested

Chiropractic treatment 2x4 of the right knee) .The MTUS, ACOEM Guidelines, Chapter 12 Low Back Complaints were cited. On 12/23/2014 Utilization Review non-certified a request for Compound Medications: Flurbiprofen 10%, Capsaicin 0.025%, Camphor 2% 120 grams noting the that any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Evidence based guidelines do not consistently support compound medications including Ketoprofen, lidocaine (in creams, lotion or gels), capsaicin in a 0.0375% formulation, baclofen and other muscle relaxants, and gabapentin and other Antiepilepsy drugs for topical applications. The MTUS Chronic Pain Medical Treatment NSAIDs were cited. On 12/23/2014 Utilization Review non-certified a request for Norco 10/325mg #120, noting there was no documentation that the prescriptions are from a single practitioner and are taken as directed, the lowest possible dose is being prescribed, and there will be ongoing review and documentation of pain relief, functional status, appropriate medication use and side effects. MTUS Chronic Pain Medical Treatment Guidelines and Official Disability Guidelines (ODG pain chapter) were cited. On 12/23/2014 Utilization Review non-certified a request for Compound Medications: Ketoprofen 10%, Cyclobenzaprine 3%, Lidocaine 5% 120 grams noting that evidence based guidelines do not consistently support compound medications including Ketoprofen,or lidocaine (in creams, lotion or gels) for topical applications. The MTUS, ACOEM Guidelines, (or ODG) were cited. On 12/23/2014 Utilization Review non-certified a request for Ortho Shockwave Right Knee, noting the evidence based guidelines do not consistently support extracorporeal shockwave therapy in the management of cited injury/condition. The MTUS, ACOEM Guidelines) were cited.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

#### **Chiropractic Treatment 2X4 Right Knee: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 298-299,Chronic Pain Treatment Guidelines MTUS Chronic Pain Medical Treatment Guidelines Page(s): 58.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 339, 346,Postsurgical Treatment Guidelines Page(s): 25.

**Decision rationale:** According to California MTUS/ACOEM Guidelines, Manual Therapy or Chiropractic Therapy, is recommended for chronic pain if it is caused by musculoskeletal conditions. ACOEM recommends against chiropractic manipulation for the knee, elbow, forearm, wrist, hand, foot, and ankle. In this case, the prescription was for the right knee, which is "not recommended" per the MTUS/ACOEM. (The only exception to this is for post-surgical treatment/manipulation of the knee.) The requested chiropractic therapy is not medically necessary.

#### **Norco 10/325mg #120: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines MTUS Chronic Pain Medical Treatment Guidelines Page(s): 78, 80, and Decision based on Non-MTUS Citation Official Disability Guidelines (ODG pain chapter)

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines CA MTUS (2009), Opioids Page(s): 91-97. Decision based on Non-MTUS Citation Opioids

**Decision rationale:** According to ODG, chronic pain can have a mixed physiologic etiology of both neuropathic and nociceptive components. In most cases, analgesic treatment should begin with acetaminophen, aspirin, and NSAIDs. When these drugs do not satisfactorily reduce pain, opioids for moderate to moderately severe pain may be added. According to ODG and MTUS, Norco is a short-acting opioid analgesic, and is in a class of drugs that has a primary indication to relieve symptoms related to pain. Opioid drugs are available in various dosage forms and strengths. They are considered the most powerful class of analgesics that may be used to manage both acute and chronic pain. These medications are generally classified according to potency and duration of dosage. The treatment of chronic pain with any opioid analgesic requires review and documentation of pain relief, functional status, appropriate medication use, and side effects. A pain assessment should include current pain, intensity of pain after taking the opiate, and the duration of pain relief. In this case, there is no documentation of the medication's pain relief effectiveness, functional status, or response to ongoing opioid analgesic therapy. Medical necessity of the requested item has not been established. Of note, discontinuation of an opioid analgesic should include a taper, to avoid withdrawal symptoms. The certification of the requested medication is not medically necessary.

**Compound Medications: Flubiprofen 10%, Capsaicin 0.025%, Camphor 2% 120 grams:**  
Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, MTUS Chronic Pain Medical Treatment Page(s): 111, 112.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints, Chronic Pain Treatment Guidelines CA MTUS (2009), Topical Analgesics Page(s): 111-113.

**Decision rationale:** According to the California MTUS Guidelines (2009), topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. These agents are applied topically to painful areas with advantages that include lack of systemic side effects, absence of drug interactions, and no need to titrate. Many agents are compounded as monotherapy or in combination for pain control including, for example, NSAIDs, opioids, capsaicin, local anesthetics or antidepressants. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. In this case, the topical analgesic compound is Flubiprofen 10%, Capsaicin 0.025%, Camphor 2%. This medication contains capsaicin, which is only recommended as an option in patients who have not responded or are intolerant to other treatments, per MTUS. There is no documentation of intolerance to other previous medications. Medical necessity for the requested topical medication has not been established. The requested treatment is not medically necessary.

### **Acupuncture 1X4 Right Knee: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Acupuncture Treatment Guidelines. Decision based on Non-MTUS Citation Official Medical Fee Schedule (OMFS)

**MAXIMUS guideline:** Decision based on MTUS Acupuncture Treatment Guidelines.

**Decision rationale:** The California MTUS Acupuncture guidelines apply to all acupuncture requests, for all body parts and for all acute or chronic, painful conditions. According to the Acupuncture Medical Treatment Guidelines, acupuncture is used as an option when pain medication is reduced or not tolerated. It may be used as an adjunct to physical rehabilitation and/or surgical intervention to hasten recovery. The treatment guidelines support acupuncture treatment to begin as an initial treatment of 3-6 sessions over no more than two weeks. If functional improvement is documented, as defined by the guidelines further treatment will be considered. In this case, the requested acupuncture sessions (1 session/week over 4 weeks) exceed the recommended 3-6 sessions in up to 2 weeks. Medical necessity of the requested acupuncture has not been established. The requested medication is not medically necessary.

### **Ortho Shockwave Right Knee: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Page(s): 235. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), American College of Sports Medicine

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 13 Knee Complaints. Decision based on Non-MTUS Citation Knee Medscape Internal Medicine

**Decision rationale:** Extracorporeal shock wave therapy (ESWT) is a noninvasive treatment proposed to treat refractory tendonopathies such as, plantar fasciitis. It has also been introduced as an alternative to surgery for patients that have not responded to other conservative therapies. ESWT is a noninvasive treatment that involves delivery of low or high energy shock waves via a device to a specific site within the body. These pressure waves travel through fluid and soft tissue; their effects occur at sites where there is a change in impedance, such as the bone/soft tissue interface. Low-energy shock wave treatments are generally given in one session and usually require some type of anesthesia. In this case, the guidelines do not support ESWT in the management of knee pain. Medical necessity of the requested ESWT has not been established. The requested treatment is not medically necessary.

### **Right Knee Patella Brace: 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)

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation The Knee DME

**Decision rationale:** There is no documentation necessitating a right knee patella brace. According to ODG, a knee brace is indicated if there is evidence of knee instability. There was no evidence of right knee instability documented on physical exam. Evidence-based guidelines necessitate documentation of a diagnosis or a condition such as, knee instability or meniscal cartilage repair. Medical necessity for the requested knee patella brace has not been supported or established. The requested item is not medically necessary.

**Compound Medications: Ketoprofen 10%, Cyclobenzaprine 3%, Lidocaine 5% 120 grams:**  
Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, MTUS Chronic Pain Medical Treatment Page(s): 111, 112.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints, Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113.

**Decision rationale:** According to the California MTUS Guidelines (2009), topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. These agents are applied topically to painful areas with advantages that include lack of systemic side effects, absence of drug interactions, and no need to titrate. Many agents are compounded as monotherapy or in combination for pain control including, for example, NSAIDs, opioids, capsaicin, local anesthetics or antidepressants. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. In this case, there is no documentation of intolerance to other previous oral medications. MTUS guidelines state that Ketoprofen, lidocaine, capsaicin and/or muscle relaxants (Cyclobenzaprine in this case) are not recommended for topical applications. Medical necessity for Ketoprofen 10%, Cyclobenzaprine 3%, Lidocaine 5% has not been established. The requested treatment is not medically necessary.