

<b>Case Number:</b>	CM15-0122903		
<b>Date Assigned:</b>	07/07/2015	<b>Date of Injury:</b>	06/10/2013
<b>Decision Date:</b>	08/07/2015	<b>UR Denial Date:</b>	06/12/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/25/2015

### 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: California, Texas, Florida

Certification(s)/Specialty: Anesthesiology, Pain Management, Hospice & Palliative Medicine

### 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 63 year old male, who sustained an industrial injury on 6/10/13. He reported twisting his right knee causing pain and swelling. The injured worker was diagnosed as having knee pain, injury of peroneal nerve, and tear of the medial meniscus. Treatment to date has included right knee arthroscopy with partial medial meniscectomy on 2/13/14, physical therapy, and medication. On 5/8/15, pain was rated as 2.5/10 with medication and 8/10 without medication. On 6/5/15, pain was rated as 4/10 with medication and 8/10 without medication. The injured worker had been taking Hydromorphone since at least 3/20/15. Currently, the injured worker complains of right knee pain. The treating physician requested authorization for Osteo Bi-Flex 200-250mg #60, Hydromorphone 4mg #60, and Terocin patches 4-4% #60 with 2 refills.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**60 caplets of Osteo Bi-Flex 250-200mg: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Glucosamine (and Chondroitin Sulfate).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 50 of 127. Decision based on Non-MTUS Citation [www.guideline.gov](http://www.guideline.gov), [www.drugs.com](http://www.drugs.com).

**Decision rationale:** Regarding the request for Osteo Bi-Flex 250-200mg (glucosamine/Chondroitin), CA MTUS states that glucosamine/Chondroitin is recommended as an option given its low risk, in patients with moderate arthritis pain, especially for knee osteoarthritis. However Osteo Bi-Flex is not specifically mentioned in CA MTUS, ODG, or National Guideline Clearinghouse (NCG) do not specifically talk about this medication. Drugs.com states this medicine contains glucosamine and Chondroitin in the 200mg 250 mg strength however Osteo Bi-glex plus has Methylsulfonylmethane added and NCG has no recommendation for this added substance. Within the documentation available for review, the requesting physician has down Osteo Bi-Flex plus (500/83/400) as the medicine the patient is currently taking and to continue to take not the Osteo Bi-Flex (250/200). Additionally there is no mention of any specific analgesic benefit or objective functional improvement from this medicine. Without further clarification regarding these issues, the currently requested Osteo Bi- Flex 250-200mg (glucosamine/Chondroitin) is not medically necessary.

**60 tablets of Hydromorphone 4mg:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, specific drug list, Hydromorphone (Dilaudid); Opioids, criteria for use.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 44, 47, 75-79, 120 of 127.

**Decision rationale:** Regarding the request for Hydromorphone, California Pain Medical Treatment Guidelines state that Hydromorphone is an opiate pain medication. 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. Within the documentation available for review, there is no indication that the medication is improving the patient's function (in terms of specific examples of objective functional improvement) and no discussion regarding aberrant use. As such, there is no clear indication for ongoing use of the medication. Opioids should not be abruptly discontinued, but fortunately, the last reviewer modified the current request to allow tapering. In light of the above issues, the currently requested Hydromorphone is not medically necessary.

**60 Terocin Patches 4-4% with 2 refills:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111-113 of 127.

**Decision rationale:** Regarding the request for Terocin, Terocin is a combination of methyl salicylate, menthol, lidocaine and capsaicin. Chronic Pain Medical Treatment Guidelines state that any compounded product that contains at least one drug or drug class that is not recommended is not recommended. Regarding the use of topical nonsteroidal anti-inflammatory, guidelines state that the efficacy in clinical trials for this treatment modality has been inconsistent and most studies are small and of short duration. Topical NSAIDs have been shown in meta-analysis to be superior to placebo during the 1st 2 weeks of treatment osteoarthritis, but either not afterwards or with the diminishing effect over another two-week period. Regarding use of capsaicin, guidelines state that it is recommended only as an option for patients who did not respond to or are intolerant to other treatments. Regarding the use of topical lidocaine, guidelines state that it is recommended for localized peripheral pain after there is evidence of a trial of first-line therapy. Within the documentation available for review, there is no indication that the patient is unable to tolerate oral NSAIDs. Oral NSAIDs have significantly more guideline support compared with topical NSAIDs. Additionally, there is no indication that the topical NSAID is going to be used for short duration. Additionally, there is no documentation of localized peripheral pain with evidence of failure of first-line therapy as recommended by guidelines prior to the initiation of topical lidocaine. Finally, there is no indication that the patient has been intolerant to or did not respond to other treatments prior to the initiation of capsaicin therapy. In the absence of clarity regarding those issues, the currently requested Terocin is not medically necessary.