

<b>Case Number:</b>	CM15-0171316		
<b>Date Assigned:</b>	10/06/2015	<b>Date of Injury:</b>	10/24/2002
<b>Decision Date:</b>	11/18/2015	<b>UR Denial Date:</b>	08/18/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/31/2015

### 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, Hawaii

Certification(s)/Specialty: Physical Medicine & Rehabilitation

### 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 53 year old female who sustained an industrial injury on 10-24-2002. According to a progress report dated 07-30-2015, the injured worker was recently diagnosed with a dislocated left knee, bilateral pulmonary embolism, deep vein thrombosis and blood clots in each leg. The left knee was currently infected and was being treated with Vancomycin. A knee fusion was going to be rescheduled depending on lab results and diagnostic findings. Diagnoses included chronic intractable pain, left knee ankylosis and inflammatory process response to total knee arthroplasty status postoperative infection, chronic opiate pain management with daily morphine analgesic equivalency of 608 mg, delayed bone healing complicating total knee arthroplasty responding to Forteo or Teriparatide injectable, status post left knee internal prosthesis with increased reactivity in the left tibial spine in the region tibial component that extends 10.6 centimeters into the tibial diaphysis with CT scan evidence of 1-2 millimeter lucency that surrounds the tibial component most pronounced along the medial distal margin with 3 millimeter lucency, refractory depression aggravated by chronic pain partially controlled with Pristiq or Desvenlafaxine, a serotonin-norepinephrine reuptake inhibitor agent, Methylphenidate and dopaminergic agonist to reduce depression, sleep dysfunction, gastrointestinal pain aggravated by medications prescribed for the injury and partly controlled with proton pump inhibitor medications, obesity due to inability to bear weight on the lower extremity, left leg numbness and paresthesias in distribution of left peroneal nerve and postoperative left knee wound infection with Grade 3 open dehiscence. Daily morphine analgesic equivalency included Oxycontin 480 mg and Hydromorphone 128 mg. Lamictal and Topiramate continued to reduce her neuralgia and the effect on her ability to sleep through a

full sleep cycle. Methylphenidate 10 mg three times a day had reduced the severity of pain, anxiety and pain induced depression by over 50% and had assisted in increasing focus impaired by her lack of sleep from her chronic pain. Pristiq and Viibryd had controlled the severity of her pain induced depression. The provider noted that due to an increased level of pain, Fentanyl 50 mcg per hour every 3 days would be prescribed. The provider noted that activities of daily living continued to be significantly limited by the severity of pain and postoperative knee infection, but was still "stable" with her current medication regimen. The provider also noted that the injured worker was unable to care for herself, dress, clean left knee wound, transfer safely from bed to wheelchair to standing position or bathe herself and that a home health aide was required for 8 hours per day 7 days per week. Pain was rated 7-8 on a scale of 1-10. The injured worker was very upset with her pain. She transported using a wheel chair with the left leg elevated and a rigid knee extension brace. Examination of the left knee was not attempted. The treatment plan included continuation of medications. Authorization requests dated 07-30-2015 were submitted for review. The requested services included electric wheelchair, home health aide, Fentanyl, Viibryd, Oxycontin, Methylphenidate, Topiramate, Omeprazole, Pristiq, Docusate and Lamotrigine. According to a previous progress report dated 02-26-2015, the provider noted that Methylphenidate had increased concentration and without it, the injured worker experienced difficulty with focus and concentration. On 08-18-2015, Utilization Review non-certified the request for Methylphenidate 10 mg #90 and authorized the request for Oxycontin-Oxycodone ER, Docusate and Omeprazole.

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

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

#### **Methylphenidate 10mg #90: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation National guideline clearinghouse Billiard M, Dauvilliers Y, Dolenc-Groselj L, Lammers GI, Mayer G, Sonka K. Management of narcolepsy in adults. In: Gilhus NE, Barnes MP, Brainin M, editor(s). European handbook of neurological management 2nd ed. Vol 1. Oxford (UK): Wiley-Blackwell; 2011 p. 513-28.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation National Institutes of Health, National Library of Medicine, <https://www.nlm.nih.gov/medlineplus/druginfo/meds/a682188.html>.

**Decision rationale:** The patient presents with depression secondary to chronic pain left knee pain. The current request is for Methylphenidate 10mg #90. The treating physician report dated 9/9/15 (403B) states, "Methylphenidate 10 mg three times a day has reduced the severity of pain induced depression by over 50% and has assisted in increasing focus impaired by her lack of sleep from her chronic pain." MTUS or ODG guidelines do not address Methylphenidate. National Institutes of Health, National Library of Medicine, and <https://www.nlm.nih.gov/medlineplus/druginfo/meds/a682188.html> states the following: "Methylphenidate can be habit-forming. Do not take a larger dose, take it more often, take it for a longer time, or take it in a different way than prescribed by your doctor. If you take too much

methylphenidate, you may find that the medication no longer controls your symptoms, you may feel a need to take large amounts of the medication, and you may experience unusual changes in your behavior." Methylphenidate is used as part of a treatment program to control symptoms of attention deficit hyperactivity disorder (ADHD; more difficulty focusing, controlling actions, and remaining still or quiet than other people who are the same age) in adults and children. Methylphenidate (Ritalin, Ritalin SR, Methylin, and Methylin ER) is also used to treat narcolepsy (a sleep disorder that causes excessive daytime sleepiness and sudden attacks of sleep). In this case, the patient does not have a diagnosis of ADHD or narcolepsy, and available guidelines state the medication should not be used to treat tiredness that is not caused by narcolepsy. The current request is not medically necessary.