

<b>Case Number:</b>	CM15-0177588		
<b>Date Assigned:</b>	09/18/2015	<b>Date of Injury:</b>	07/19/2005
<b>Decision Date:</b>	11/18/2015	<b>UR Denial Date:</b>	08/15/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/09/2015

### 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, Arizona

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 49 year old male who sustained an industrial injury on 07/19/2005. The injured worker was diagnosed with right knee medial meniscus tear and underwent arthroscopy of the right knee in February 2006 and October 2006. According to the treating physician's progress report on July 29, 2015, the injured worker experiences right knee pain rated 6 out of 10 on the pain scale. The injured worker described the pain as intermittent and sharp with giving out and negative for falls. Several documents within the submitted medical records are difficult to decipher. The provider documented no functional change since the last physical examination on July 2, 2015. The injured worker is Permanent & Stationary (P&S) and not working. Prior treatments documented to date have included diagnostic testing with recent magnetic resonance arthrogram (MRA) on May 14, 2015, surgery, Synvisc injections, physical therapy, acupuncture therapy and medications. Current medications were listed as Norco, Naproxen, Prilosec and topical compounded analgesics. Urine drug screening in February 2015 was positive for methamphetamine and negative for Hydrocodone. Treatment plan consists of home exercise program, orthopedic referral and the requested authorization for medications and a solar care infrared heating system for right knee. The Utilization Review determined the request for Norco 5-325mg #60 with 1 refill, Naproxen 550mg #60 with 1 refill, Prilosec 70mg #30 with 1 refill, Compound medication: Flurbi-Menthol-Caps-Cam cream with 1 refill and solar care FIR heating system for right knee was not medically necessary on 08/15/2015.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Norco 5-325mg #60, 1 refill:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids, criteria for use.

**Decision rationale:** The California MTUS guidelines allows for the use of opioid medication, such as Norco, for the management of chronic pain and outlines clearly the documentation that would support the need for ongoing use of an opioid. These steps include documenting pain and functional improvement using validated measures at 6 months intervals, documenting the presence or absence of any adverse effects, documenting the efficacy of any other treatments and of any other medications used in pain treatment. There is no significant pain reduction stated within the records, using validated pain scores, attributed to Norco, nor is there mention of significant enhancement of activities of daily living. The efficacy of this drug has not been established and long-term use is not recommended. This request is not medically necessary.

**Prilosec 70mg #30, 1 refill:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): NSAIDs, GI symptoms & cardiovascular risk.

**Decision rationale:** According to the MTUS Chronic Pain Guidelines, Proton Pump Inhibitors are used to treat symptoms of gastritis, peptic ulceration, acid reflux, and/or dyspepsia related to non-steroidal anti-inflammatories (NSAIDs). Those on NSAIDs at high risk for GI events should be considered for antacid therapy. Factors determining if a patient is at risk for gastrointestinal events include age greater than 65 years, history of peptic ulcer, GI bleeding or perforation, concurrent use of aspirin, corticosteroids and/or an anticoagulant or high dose/multiple NSAID use. Within the most recent July and August 2015 PR-2 notes, there is no mention of gastritis on ROS, nor is there mention of Prilosec being effective in the treatment of GERD secondary to NSAID use. The injured worker is not noted to have significant GI risks. The medical necessity for the requested medication has not been established. This request is not medically necessary.

**Naproxen 550mg #60, 1 refill:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): NSAIDs (non-steroidal anti-inflammatory drugs).

**Decision rationale:** As per MTUS Chronic Pain Guidelines, NSAIDs are useful for osteoarthritis related pain. Due to side effects, and risks of adverse reactions, MTUS recommends as low a dose as possible for as short a course as possible. Acetaminophen should be considered initial therapy in those with mild to moderate osteoarthritic pain. Within the submitted records, the recent PR-2 notes document medial meniscus tear and status post arthroscopy x2, with no significant findings on exam or mention of osteoarthritis. Furthermore, the efficacy of Naproxen has not been adequately documented to support long-term use. This request is not medically necessary.

**Compound - Flurbi-Menthol-Caps Camph cream with 1 refill:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Topical Analgesics.

**Decision rationale:** Per MTUS guidelines, the use of topical analgesics in the treatment of chronic pain is largely experimental, and when used, is primarily recommended for the treatment of neuropathic pain when trials of first line treatments such as anti-convulsants and/or anti-depressants have failed. The guidelines go on to state that when any compounded product contains 1 medication that is not recommended, the compounded product as a whole is not recommended. The request cannot be supported. The requested cream contains topical Flurbiprofen, Capsaicin, Camphor, and Menthol. Topical NSAIDs (Flurbiprofen) are indicated for "Osteoarthritis or Tendonitis, in particular that of the knee, elbow, or other joints amenable to topical application." They are recommended for short-term use (generally, 4-12 weeks). Capsaicin is recommended "as an option for those who have not responded or are intolerant of other treatments for neuropathic pain." There is no mention of efficacy as it pertains to this topical medication and use has been ongoing for more than 4-12 weeks. Medical necessity has not been established. This request is not medically necessary.

**Solar care FIR heating system for right knee:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Knee & Leg.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back, Infrared Therapy.

**Decision rationale:** The ODG discusses Solar Care Deep Heating infrared units as it pertains to the low back. ODG Guidelines under the Low Back chapter on infrared therapy states, "Not recommended over other heat therapies. Where deep heating is desirable, providers may

consider a limited trial of IR therapy for treatment of acute lower back pain, but only if used as an adjunct to a program of evidence-based conservative care exercise." As it pertains to the Solar Care product for the knee, the provider mentions he wants the Solar care product to empower my patient to become independent and to help them take a role in the management of their symptoms. There is no mention of failure of topical ice or heat and why deep heating is preferred over other heating mechanisms. The guidelines have not been met. This request is not medically necessary.