

Case Number:	CM15-0179047		
Date Assigned:	09/21/2015	Date of Injury:	01/13/2015
Decision Date:	10/23/2015	UR Denial Date:	08/19/2015
Priority:	Standard	Application Received:	09/11/2015

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: North Carolina

Certification(s)/Specialty: Family Practice

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 with an industrial injury dated 01-13-2015. Medical record review indicates he is being treated for right knee chondromalacia and status post-surgery - right knee. He presents on 07-07-2015 with complaints of frequent right knee pain, which increased with prolonged walking, flexing, extension, ascending or descending stairs and squatting. The injured worker rated his right knee pain as 9 on a scale of 1-10. The progress note dated 05-20-2015 and 06-18-2015 document the injured worker's pain as 5 out of 10. Current work status is listed as "currently working." Objective findings are documented as mild swelling present at the right knee with tenderness to palpation of the anterior knee. The following tests were negative - McMurray's, Valgus, Varus, Anterior Drawer and Posterior Drawer. Prior treatment included physical therapy and arthroscopic repair of right knee on 03-29-2015. The treatment plan included topical pain creams, acupuncture and urine toxicology testing. The request for authorization dated 07-07-2015 is for: Urine toxicology testing. Flurbiprofen 20%. Baclofen 5%. Camphor 2%. Menthol 2%. Dexamethasone micro 0.2%. Capsaicin 0.025%. Hyaluronic acid 0.2% in cream base 240 gm. Amitriptyline HCL 10%. Gabapentin 10%. Bupivacaine HCL 5%. Hyaluronic acid 0.2% in cream base 240 gm. On 08-09-2015, the request for the treatments listed below was non-certified by utilization review: Urine toxicology testing. Flurbiprofen 20%. Baclofen 5%. Camphor 2%. Menthol 2%. Dexamethasone micro 0.2%. Capsaicin 0.025%. Hyaluronic acid 0.2% in cream base 240 gm. Amitriptyline HCL 10%. Gabapentin 10%. Bupivacaine HCL 5%. Hyaluronic acid 0.2% in cream base 240 gm.

IMR ISSUES, DECISIONS AND RATIONALES

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

Flurbiprofen 20%/Baclofen 5%/Camphor 2%/Menthol 2%/Dexamethasone micro 0.2%/Capsaicin 0.025%/Hyaluronic acid 0.2% in cream base 240gm: Upheld

Claims Administrator guideline: Decision based on MTUS Knee Complaints 2004, and Chronic Pain Medical Treatment 2009. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Chapter, Knee & Leg Chapter.

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

Decision rationale: The California chronic pain medical treatment guidelines section on topical analgesics states: Recommended as an option as indicated below. Largely experimental in use with few randomized controlled trials to determine efficacy or safety. Primarily recommended for neuropathic pain when trials of anti-depressants and anti-convulsants have failed. (Namaka, 2004) These agents are applied locally to painful areas with advantages that include lack of systemic side effects, absence of drug interactions, and no need to titrate. (Colombo, 2006) Many agents are compounded as monotherapy or in combination for pain control (including NSAIDs, opioids, capsaicin, local anesthetics, anti-depressants, glutamate receptor antagonists, adrenergic receptor agonist, adenosine, cannabinoids, cholinergic receptor agonists, agonists, prostanoids, bradykinin, adenosine triphosphate, biogenic amines, and nerve growth factor). (Argoff, 2006) There is little to no research to support the use of many of these agents. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. The requested medication contains ingredients (baclofen) which are not indicated per the California MTUS for topical analgesic use. Therefore, the request is not medically necessary.

Amitriptyline HCL 10%/Gabapentin 10%/Bupivacaine HCL 5%/Hyaluronic acid 0.2% in cream base 240gm: Upheld

Claims Administrator guideline: Decision based on MTUS Knee Complaints 2004, and Chronic Pain Medical Treatment 2009. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Chapter, Knee & Leg Chapter.

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

Decision rationale: The California chronic pain medical treatment guidelines section on topical analgesics states: Recommended as an option as indicated below. Largely experimental in use with few randomized controlled trials to determine efficacy or safety. Primarily recommended for neuropathic pain when trials of anti-depressants and anti-convulsants have failed. (Namaka, 2004) These agents are applied locally to painful areas with advantages that include lack of systemic side effects, absence of drug interactions, and no need to titrate. (Colombo, 2006) Many agents are compounded as monotherapy or in combination for pain control (including NSAIDs, opioids, capsaicin, local anesthetics, antidepressants, glutamate receptor antagonists, adrenergic receptor agonist, adenosine, cannabinoids, cholinergic receptor agonists, agonists, prostanoids, bradykinin, adenosine triphosphate, biogenic amines, and nerve growth factor). (Argoff, 2006) There is little to no research to support the use of many of these agents. Any

compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. The requested medication contains ingredients (gabapentin), which are not indicated per the California MTUS for topical analgesic use. Therefore, the request is not medically necessary.

Urine toxicology testing: Upheld

Claims Administrator guideline: Decision based on MTUS Knee Complaints 2004, and Chronic Pain Medical Treatment 2009. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Chapter, Knee & Leg Chapter.

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

Decision rationale: The California chronic pain medical treatment guidelines section on opioids states: On-Going Management. Actions Should Include: (a) Prescriptions from a single practitioner taken as directed, and all prescriptions from a single pharmacy. (b) The lowest possible dose should be prescribed to improve pain and function. (c) Office: Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. Pain assessment should include: current pain; the least reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid; how long it takes for pain relief; and how long pain relief lasts. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. Information from family members or other caregivers should be considered in determining the patient's response to treatment. The 4 A's for Ongoing Monitoring: Four domains have been proposed as most relevant for ongoing monitoring of chronic pain patients on opioids: pain relief, side effects, physical and psychosocial functioning, and the occurrence of any potentially aberrant (or non-adherent) drug-related behaviors. These domains have been summarized as the "4 A's" (analgesia, activities of daily living, adverse side effects, and aberrant drug taking behaviors). The monitoring of these outcomes over time should affect therapeutic decisions and provide a framework for documentation of the clinical use of these controlled drugs. (Passik, 2000) (d) Home: To aid in pain and functioning assessment, the patient should be requested to keep a pain diary that includes entries such as pain triggers, and incidence of end-of-dose pain. It should be emphasized that using this diary will help in tailoring the opioid dose. This should not be a requirement for pain management. (e) Use of drug screening or inpatient treatment with issues of abuse, addiction, or poor pain control. (f) Documentation of misuse of medications (doctor-shopping, uncontrolled drug escalation, drug diversion). (g) Continuing review of overall situation with regard to non-opioid means of pain control. (h) Consideration of a consultation with a multidisciplinary pain clinic if doses of opioids are required beyond what is usually required for the condition or pain does not improve on opioids in 3 months. Consider a psych consult if there is evidence of depression, anxiety or irritability. Consider an addiction medicine consult if there is evidence of substance misuse. The California MTUS does recommend urine drug screens as part of the criteria for ongoing use of opioids. The patient was on no chronic opioids at the time of request and not showing aberrant behavior. Therefore, the request is not medically necessary.