

Case Number:	CM15-0094340		
Date Assigned:	05/20/2015	Date of Injury:	02/16/2012
Decision Date:	09/23/2015	UR Denial Date:	05/08/2015
Priority:	Standard	Application Received:	05/15/2015

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: California
 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:

This is a 40-year-old male with a February 16, 2012 date of injury. A progress note dated May 6, 2015 documents subjective findings (pain unchanged; pain rated at a level of 7/10), objective findings (squatting with difficulty; decreased range of motion of the right knee; tenderness along the medial and lateral joint line; normal motor strength), and current diagnoses (right knee pain). Treatments to date have included medications, physical therapy, home exercise, magnetic resonance imaging of the right knee (showed inferior surface tear involving the posterior horn and body of the medial meniscus, and mild compartment chondral fraying), and surgery. The treating physician documented a plan of care that included Ibuprofen, Gabapentin, Dendracin ointment, Cymbalta, Acupuncture to the right knee, and steroid injections to the right knee.

IMR ISSUES, DECISIONS AND RATIONALES

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

Ibuprofen 600 mg Qty 60 with 0 refills: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-inflammatory Page(s): 22.

Decision rationale: The patient presents with right knee pain, rated 7/10. The request is for Ibuprofen 600 mg qty 60 with 0 refills. Patient is status post right knee surgery 07/23/12. Physical examination to the right knee on 04/15/15 revealed tenderness to palpation over the medial joint line. Per 05/06/15 progress report, patient's diagnosis includes right knee pain. Patient's medications, per 04/15/15 progress report include Gabapentin, Ibuprofen, and Dendracin Ointment. Patient is permanent and stationary. MTUS Chronic Pain Medical Treatment Guidelines, pg 22 for Anti-inflammatory medications states: Anti-inflammatories are the traditional first line of treatment, to reduce pain so activity and functional restoration can resume, but long-term use may not be warranted. A comprehensive review of clinical trials on the efficacy and safety of drugs for the treatment of low back pain concludes that available evidence supports the effectiveness of non-selective nonsteroidal anti-inflammatory drugs (NSAIDs) in chronic LBP and of antidepressants in chronic LBP. MTUS p60 also states, "A record of pain and function with the medication should be recorded," when medications are used for chronic pain. Treater does not discuss request. Patient has received prescriptions for Ibuprofen from 02/04/15 through 05/06/15. In this case, the treater has not documented how this medication has been effective in management of pain and function. MTUS page 60 require recording of pain and function when medications are used for chronic pain. Given the lack of documentation, as required by guidelines, the request is not medically necessary.

Gabapentin 600 mg Qty 60 with 0 refills: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Gabapentin (Neurontin, Gabarone) Page(s): 18, 19.

Decision rationale: The patient presents with right knee pain, rated 7/10. The request is for Gabapentin 600 mg qty 60 with 0 refills. Patient is status post right knee surgery 07/23/12. Physical examination to the right knee on 04/15/15 revealed tenderness to palpation over the medial joint line. Per 05/06/15 progress report, patient's diagnosis includes right knee pain. Patient's medications, per 04/15/15 progress report include Gabapentin, Ibuprofen, and Dendracin Ointment. Patient is permanent and stationary. MTUS has the following regarding Gabapentin on pg 18, 19: "Gabapentin (Neurontin, Gabarone, generic available) has been shown to be effective for treatment of diabetic painful neuropathy and postherpetic neuralgia and has been considered as a first-line treatment for neuropathic pain." MTUS p60 also states, "A record of pain and function with the medication should be recorded," when medications are used for chronic pain. Treater has not discussed reason for the request. In review of the medical records provided, a prescription for Gabapentin was first note in progress report dated 02/04/14 and the patient has been utilizing these medications at least since then. However, the treater has not discussed how this medication significantly reduces patient's pain and helps with activities of daily living. MTUS page 60 states, "A record of pain and function with the medication should be

recorded," when medications are used for chronic pain. The request does not meet all the criteria listed by MTUS; therefore, it is not medically necessary.

Dendracin ointment 100 g, Qty 1, with 4 refills: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111.

Decision rationale: The patient presents with right knee pain, rated 7/10. The request is for Dendracin ointment 100 gm, qty 1, with 4 refills. Patient is status post right knee surgery 07/23/12. Physical examination to the right knee on 04/15/15 revealed tenderness to palpation over the medial joint line. Per 05/06/15 progress report, patient's diagnosis includes right knee pain. Patient's medications, per 04/15/15 progress report include Gabapentin, Ibuprofen, and Dendracin Ointment. Patient is permanent and stationary. Per dailymed.nlm.nih.gov, The National Library of Medicine, National Institutes of Health state that Dendracin is a compound of Capsaicin .0375%, Menthol 10%, and Methyl Salicylate. MTUS Guidelines pages 111 have the following regarding topical creams: "Topical Analgesics: Recommended as an option as indicated below. Non-steroidal anti-inflammatory agents (NSAIDs): 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 first 2 weeks of treatment for osteoarthritis, but either not afterward, or with a diminishing effect over another 2-week period. Guidelines also do not support the use of topical NSAIDs such as Voltaren for axial, spinal pain, but supports its use for peripheral joint arthritis and tendinitis." MTUS, pg. 29, Capsaicin, topical, "Indications: There are positive randomized studies with capsaicin cream in patients with osteoarthritis, fibromyalgia, and chronic non-specific back pain, Capsaicin is generally available as a 0.025% formulation (as a treatment for osteoarthritis) and a 0.075% formulation (primarily studied for post-herpetic neuralgia, diabetic neuropathy and post-mastectomy pain). There have been no studies of a 0.0375% formulation of capsaicin and there is no current indication that this increase over a 0.025% formulation would provide any further efficacy." The treater has not specifically addressed this request. Review of the medical records indicate that the patient has been prescribed Dendracin cream since at least 01/30/15, though there is no discussion of medication efficacy in the subsequent reports. MTUS guidelines require documentation of efficacy or functional improvement attributed to medications in order to substantiate continued use. Furthermore, 0.0375% formulation of capsaicin is not supported by MTUS for topical use in ointment form. Therefore, the request is not medically necessary.

Cymbalta 50 mg Qty 30 with 1 refills: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-depressants Page(s): 16-17.

Decision rationale: The patient presents with right knee pain, rated 7/10. The request is for Cymbalta 50 mg qty 30 with 1 refill. Patient is status post right knee surgery 07/23/12. Physical examination to the right knee on 04/15/15 revealed tenderness to palpation over the medial joint line. Per 05/06/15 progress report, patient's diagnosis includes right knee pain. Patient's medications, per 04/15/15 progress report include Gabapentin, Ibuprofen, and Dendracin Ointment. Patient is permanent and stationary. Regarding Cymbalta, the MTUS guidelines page 16-17 Anti-depressants for Chronic pain section, states, "Duloxetine (Cymbalta) is FDA-approved for anxiety, depression, diabetic neuropathy, and fibromyalgia. Used off-label for neuropathic pain and radiculopathy. Duloxetine is recommended as a first-line option for diabetic neuropathy. Trial period: Some relief may occur in first two weeks; full benefit may not occur until six weeks." MTUS page 60 require documentation of pain and function when medications are used for chronic pain. In 04/15/15 progress report, treater is adding Cymbalta to patient's medications, for neuropathic and musculoskeletal benefits. However, treater has not documented analgesia or functional improvements attributed to this medication in subsequent reports. MTUS guidelines required documentation of analgesia and functional improvement to substantiate continued use of medications when used for pain, and none is provided. Therefore, the request is not medically necessary.

Acupuncture to the Right Knee, 2 times per wk for 3 wks, 6 sessions: Overturned

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

Decision rationale: The patient presents with right knee pain, rated 7/10. The request is for acupuncture to the right knee, 2 times per wk for 3 wks, 6 sessions. Patient is status post right knee surgery 07/23/12. Physical examination to the right knee on 04/15/15 revealed tenderness to palpation over the medial joint line. Per 05/06/15 progress report, patient's diagnosis includes right knee pain. Patient's medications, per 04/15/15 progress report include Gabapentin, Ibuprofen, and Dendracin Ointment. Patient is permanent and stationary. 9792.24.1. Acupuncture Medical Treatment Guidelines. MTUS pg. 13 of 127 states: "(i) Time to produce functional improvement: 3 to 6 treatments; (ii) Frequency: 1 to 3 times per week; (iii) Optimum duration: 1 to 2 months. (D) Acupuncture treatments may be extended if functional improvement is documented as defined in Section 9792.20(e)." ODG-TWC, under Acupuncture Section states, "With evidence of objective functional improvement, total of up to 8-12 visits over 4-6 weeks (Note: The evidence is inconclusive for repeating this procedure beyond an initial short course of therapy)." In progress report dated 04/15/15, treater recommends a trial of acupuncture since the patient still has residual pain. The patient continues with pain in the right knee. Review of the medical records did not indicate prior acupuncture treatment. Given the patient's condition, the requested 6 sessions of acupuncture appears medically reasonable and is within MTUS guidelines. Therefore, the request is medically necessary.

Steroid injections to the Right Knee, one time: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee & Leg (Acute & Chronic) Chapter, under Corticosteroid injections.

Decision rationale: The patient presents with right knee pain, rated 7/10. The request is for steroid injection to the right knee, one time. Patient is status post right knee surgery 07/23/12. Physical examination to the right knee on 04/15/15 revealed tenderness to palpation over the medial joint line. Per 05/06/15 progress report, patient's diagnosis includes right knee pain. Patient's medications, per 04/15/15 progress report include Gabapentin, Ibuprofen, and Dendracin Ointment. Patient is permanent and stationary. ODG Guidelines, Knee & Leg (Acute & Chronic) Chapter, under Corticosteroid injections states: "Recommended for short-term use only. Intra-articular corticosteroid injection results in clinically and statistically significant reduction in osteoarthritic knee pain 1 week after injection. Criteria for Intraarticular glucocorticosteroid injections: Documented symptomatic severe osteoarthritis of the knee, Not controlled adequately by recommended conservative treatments (exercise, NSAIDs or acetaminophen); Pain interferes with functional activities (e.g., ambulation, prolonged standing) and not attributed to other forms of joint disease... Only one injection should be scheduled to start, rather than a series of three. A second injection is not recommended if the first has resulted in complete resolution of symptoms, or if there has been no response. With several weeks of temporary, partial resolution of symptoms, and then worsening pain and function, a repeat steroid injection may be an option. The number of injections should be limited to three."The treater has not specifically addressed this request. In progress report dated 02/04/15, it is stated that the patient had one injection after the surgery, which did not help. ODG guidelines do not support a second injection if the first has resulted in complete resolution of symptoms, or if there has been no response. This request is not in accordance with guideline recommendations and therefore, is not medically necessary.