

Case Number:	CM13-0038616		
Date Assigned:	12/18/2013	Date of Injury:	11/01/2010
Decision Date:	02/12/2014	UR Denial Date:	10/09/2013
Priority:	Standard	Application Received:	10/25/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Pain Management, has a subspecialty in Disability Evaluation and is licensed to practice in California. 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 physician 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 claimant is a 58 years old female with the stated date of injury of. November 1, 2010. On November 1, 2010, the applicant was in the kitchen when she saw a mouse. She stepped backwards and she felt pain in her left knee, which she had not experienced previously. She reported her injury, and she was referred to the [REDACTED]. She was diagnosed as having a sprain of the knee and leg. She was advised to use a cane, and she was prescribed medication and physical therapy. She returned back to work the following day with restrictions, and she had follow-up visits at the [REDACTED]. Upon returning back to work, she was not allowed to work. It was not until November 17 or 18, 2010 that she began to perform modified work activities, feeding the children in the classrooms four hours a day. She remained under the care of the [REDACTED]. On November 29, 2010, [REDACTED], an orthopedic surgeon at the [REDACTED], evaluated the applicant and recommended an MRI of her left knee due to her left knee pain. On December 24, 2010, her MRI demonstrated a degenerative tear of the posterior horn and medical meniscus, and a chronic grade IV chondromalacia of the anterior compartment. On January 10, 2011, [REDACTED] recommended that she undergo a left knee arthroscopic surgery. On January 19, 2011, the applicant's work duties were changed. She returned to work in the kitchen, and she was given a chair with wheels on it to use while she was working. As she was doing so, when placing a jar onto the counter, the chair slipped and fell under her. She fell to the right side and twisted her right ankle, which did resolve, and she experienced increased pain in her left knee. She left work early on this day, and she consulted the [REDACTED]. She was subsequently off work on Thursday, Friday, and for the weekend. On January 24, 2011, [REDACTED] placed her on temporary disability. On February 24

IMR ISSUES, DECISIONS AND RATIONALES

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

Retrospective Naproxen Sodium 550mg, #120, DOS: 8/29/13: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAID Page(s): 69.

Decision rationale: CA-MTUS (effective July 18 2009) page 69 of 127, regarding the use of NSAIDs NSAIDs can increase blood pressure by an average of 5 to 6 mm in patients with hypertension. They may cause fluid retention, edema, and rarely, congestive heart failure. (Sustained blood pressure elevation in the elderly is associated with increases in hemorrhagic stroke, congestive heart failure and ischemic cardiac events.) The risk appears to be higher in patients with congestive heart failure, kidney disease or liver disease. Normotensive patients: NSAIDs appear to have minimal effect on blood pressure in normotensive patients. (Laine, 2007). Hypertensive patients: All NSAIDs have the potential to raise blood pressure in susceptible patients. The greatest risk appears to occur in patients taking the following anti-hypertensive therapy: angiotensin-converting enzyme (ACE) inhibitors; angiotensin receptor blockers; betablockers; or diuretics. In addition congestive heart failure may develop due to fluid retention. Patients with mild to moderate renal dysfunction: All NSAIDs are relatively contraindicated in patients with renal insufficiency, congestive heart failure, or volume excess (such as cirrhosis). Oral opioids are an option for treatment. This patient also has a history of diabetes mellitus and hypertension, and NSAID is relatively contra-indicated because of the possibility of worsening hypertension and accelerating the development of kidney damage in a patient with diabetes mellitus. An earlier study published in the New England Journal of Medicine in 1994 looked at the connection between painkiller use and the development of End Stage Renal Disease [ESRD], i.e. kidney failure. It concluded: A cumulative dose of 5000 or more pills containing NSAIDs was also associated with increased odds of ESRD (odds ratio, 8.8) Naproxen is a nonselective, non-steroidal anti-inflammatory medication for treatment of osteoarthritis or inflammatory conditions. Dosages are up to 1100 mg per day is typical for a duration of up to six months. There are potential GI, hypertensive or renal side effects. The present records do not define what active arthritic or inflammatory condition may be present to justify the use of this NSAID. Although the patient reported hip pain, a short course of NSAID therapy (two to three weeks) may be appropriate, but the request for naproxen 550mg #120 is not medically necessary

Retrospective Cyclobenzaprine Hydrochloride 7.5mg, #120, DOS: 8/29/13: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-spasmodics Page(s): 64.

Decision rationale: CA- MTUS (Effective July 18, 2009), page 64, section on antispasmodics, which includes Flexeril also known as Cyclobenzaprine, is used to decrease muscle spasm in conditions such as lower back pain, although it appears that these medications are often used for the treatment of musculoskeletal conditions whether spasm is present or not. The mechanism of action for most of these agents is not known. (Chou, 2004). The Recommendation is for a short course of therapy. Limited, mixed-evidence does not allow for a recommendation for chronic use. Cyclobenzaprine is a skeletal muscle relaxant and a central nervous system depressant with similar effects to tricyclic antidepressants (e.g. amitriptyline). Cyclobenzaprine is more effective than placebo in the management of back pain, although the effect is modest and comes at the price of adverse effects. It has a central mechanism of action, but it is not effective in treating spasticity from cerebral palsy or spinal cord disease. Cyclobenzaprine is associated with a number needed to treat of 3 at 2 weeks for symptom improvement. The greatest effect appears to be in the first 4 days of treatment. (Browning, 2001) (Kinkade, 2007) (Toth, 2004) See Cyclobenzaprine. Cyclobenzaprine has been shown to produce a modest benefit in treatment of fibromyalgia. Cyclobenzaprine-treated patients with fibromyalgia were 3 times more likely to report overall improvement and to report moderate reductions in individual symptoms (particularly sleep). A meta-analysis concluded that the number needed to treat for patients with fibromyalgia was 4.8. (ICSI, 2007) (Tofferi, 2004). The recommended dosage is 5-10mg thrice daily, for no longer than 2-3 weeks, with the greatest benefit in the first 4 days of therapy. The claimant continues to be symptomatic with pain accompanied by clinical deficits and limitations on exam. However, there is no documentation of ongoing muscle spasms, stiffness, or tightness, or any functional improvement. The CA-MTUS guideline recommended that treatment with this medication should be brief and not for longer than 2-3 weeks with the greatest benefit in the first 4 days of therapy. The subject injury is almost three years old and there is no basis for continued use of this medication, therefore the request for retrospective Cyclobenzaprine Hydrochloride 7.5mg, #120, DOS: 8/29/13 is not medically necessary.

Retrospective Ondansetron ODT 8mg, #30, DOS: 8/29/13: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Medicinenet.com <http://www.medicinenet.com/ondansetron-oral/article.htm>

Decision rationale: CA-MTUS (Effective July 18, 2009) is mute on this topic. According to [REDACTED], This medication is used alone or with other medications to prevent nausea and vomiting caused by cancer drug treatment (chemotherapy) and radiation therapy. It is also used to prevent and treat nausea and vomiting after surgery. It works by blocking one of the body's natural substances (serotonin) that causes vomiting. There is no information indicating any basis for nausea secondary to the above cause, therefore the retrospective Ondansetron ODT 8mg, #30, DOS: 8/29/13 is not medically necessary

Retrospective Omeprazole delayed release 20mg, #120, DOS: 8/29/13: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAID, GI Symptoms and Cardiovascular Risk Page(s): 68.

Decision rationale: CA-MTUS (Effective July 18, 2009) page section on NSAID, GI Symptoms and Cardiovascular Risk page 68, of 127. Omeprazole is recommended with precautions in patients taking NSAID, because of potential development of gastro-intestinal bleeding. According to Chronic Pain Medical Treatment Guidelines page 68 (MTUS -Effective July 18, 2009) clinicians should weight the indications for NSAIDs against both GI and cardiovascular risk factors. Determine if the patient is at risk for gastrointestinal events: (1) age > 65 years; (2) history of peptic ulcer, GI bleeding or perforation; (3) concurrent use of ASA, corticosteroids, and/or an anticoagulant; or (4) high dose/multiple NSAID (e.g., NSAID + low-dose ASA). The patient does not fall into any of these categories; hence the guideline does not apply to this patient. In addition, the medical record reviewed indicated no gastro-intestinal complaints. Based on the foregoing, the retrospective Omeprazole delayed release 20mg, #120, DOS: 8/29/13 is not medically necessary

Retrospective Quazepam 15mg, #30, DOS: 8/29/13: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepine Page(s): 24.

Decision rationale: According to Chronic Pain Medical Treatment guideline (MTUS 2009), page 24 of 127, Quazepam (a class of benzodiazepine) is not recommended for long-term use because long-term efficacy is unproven and there is a risk of dependence. Most guidelines limit use to 4 weeks. Their range of action includes sedative/hypnotic, anxiolytic, anticonvulsant, and muscle relaxant. Chronic benzodiazepines are the treatment of choice in very few conditions. Tolerance to hypnotic effects develops rapidly. Tolerance to anxiolytic effects occurs within months and long-term use may actually increase anxiety. A more appropriate treatment for anxiety disorder is an antidepressant. Tolerance to anticonvulsant and muscle relaxant effects occurs within weeks. (Baillargeon, 2003) (Ashton 2005). Quazepam is also utilized for treatment of insomnia. It has both psychiatric and sedative side effects. It has potential liver or kidney dysfunction side effects. There is nothing in the available records indicating a significant sleep disorder. Regardless, nonpharmacologic modalities of sleep therapy are preferred to medication management. There is no documentation that insomnia is a compensable condition for this claimant. The request for Quazepam 15mg, #30, DOS: 8/29/13: is not medically necessary.