

Case Number:	CM13-0038625		
Date Assigned:	12/18/2013	Date of Injury:	06/03/2010
Decision Date:	02/11/2014	UR Denial Date:	10/18/2013
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 Family Medicine and is licensed to practice in North Carolina. 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 patient is a 48-year-old male with a reported date of injury of 06/03/2010 when he fell from a ladder. His diagnoses include chronic bilateral knee pain, bilateral knee patellar tendonitis, bilateral knee chondromalacia patella and left ankle peroneal tendonitis. Treatment regimen had included medication, TENS unit, extracorporeal shock wave therapy, injections and acupuncture. Physical exam reveals the patient walking with a limp favoring the right lower extremity, with tenderness to palpation on the inferior pole of the patella of the right knee, positive McMurray's sign on the right medially and laterally. An office note dated 8/1/13 notes the patient had received previous physical therapy with minimal, but temporary relief. Utilization review decision rendered 10/17/2013 failed to certify 60 Naproxen 550mg between 9/12/13 and 12/1/13, 60 Prilosec 20 mg between 9/12/13 and 12/1/13, 1 orthopedic consult regarding bilateral knee pain between 9/12/13 and 12/1/13, 12 physical therapy sessions for bilateral knee between 9/12/13 and 12/1/13. It recommended modification of certification of tramadol ER 150 from 30 tablets to 15 tablets.

IMR ISSUES, DECISIONS AND RATIONALES

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

Naproxen 550mg #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs
Page(s): 70-73.

Decision rationale: The California MTUS makes the following recommendations concerning NSAIDs: NSAIDs (non-steroidal anti-inflammatory drugs), Specific recommendations: Osteoarthritis (including knee and hip): Recommended at the lowest dose for the shortest period in patients with moderate to severe pain. Acetaminophen may be considered for initial therapy for patients with mild to moderate pain, and in particular, for those with gastrointestinal, cardiovascular or renovascular risk factors. NSAIDs appear to be superior to acetaminophen, particularly for patients with moderate to severe pain. There is no evidence to recommend one drug in this class over another based on efficacy. In particular, there appears to be no difference between traditional NSAIDs and COX-2 NSAIDs in terms of pain relief. The main concern of selection is based on adverse effects. COX-2 NSAIDs have fewer GI side effects at the risk of increased cardiovascular side effects, although the FDA has concluded that long-term clinical trials are best interpreted to suggest that cardiovascular risk occurs with all NSAIDs and is a class effect (with Naproxen being the safest drug). There is no evidence of long-term effectiveness for pain or function. (Chen, 2008) (Laine, 2008). This patient had documented use of Anaprox, a form of naproxen, for over one year with no documented benefit of the medication. The guidelines above recommend the use of NSAIDs for the shortest period of time possible with the long-term effectiveness being unknown. Based on a lack of documented improvement on the medication, continued use cannot be recommended.

Prilosec 20mg #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs
Page(s): 68.

Decision rationale: The California MTUS states the following patient types are at high risk for gastrointestinal disease: 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). Recent studies tend to show that H. Pylori does not act synergistically with NSAIDS to develop gastroduodenal lesions. This patient has been taking NSAIDs but has no other risk factors or taking aspirin with the NSAID. There is no documentation of gastrointestinal symptoms or known disease and thus the Prilosec has no clinical indication.

Tramadol ER 150mg: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids
Page(s): 78-84.

Decision rationale: There are several proposed guidelines for the use of opioids for chronic non-malignant pain, but these have not been evaluated in clinical practice, and selection of the patient that will best respond to this treatment modality remains difficult. (Nicholas, 2006) (Stein, 2000) One of the most recent of these guidelines is the Agency Medical Director's Group (AMDG) Guidelines from Washington State. This guideline includes an opioid dosing calculator. (AMDG, 2007), Outcomes measures: It is now suggested that rather than simply focus on pain severity, improvements in a wide range of outcomes should be evaluated, including measures of functioning, appropriate medication use, and side effects. Measures of pain assessment that allow for evaluation of the efficacy of opioids and whether their use should be maintained include the following: 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. (Nicholas, 2006) (Ballantyne, 2006) A recent epidemiologic study found that opioid treatment for chronic non-malignant pain did not seem to fulfill any of key outcome goals including pain relief, improved quality of life, and/or improved functional capacity. (Eriksen,2006), Specific Opioids: Tramadol: A recent Cochrane review found that this drug decreased pain intensity, produced symptom relief and improved function for a time period of up to three months but the benefits were small (a 12% decrease in pain intensity from baseline). Adverse events often caused study participants to discontinue this medication, and could limit usefulness. There are no long-term studies to allow for recommendations for longer than three months. (Cepeda, 2006) Similar findings were found in an evaluation of a formulation that combines immediate-release vs. extended release Tramadol. Adverse effects included nausea, constipation, dizziness/vertigo and somnolence. (Burch, 2007). This patient has used tramadol greater than the three month recommendation. This is also no clear documentation addressing the outcome measures as defined above and therefore the medication cannot be recommended.

1 orthopedic consult regarding bilateral knees: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 330.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 330.

Decision rationale: This patient clearly has had symptomatic knee pain for a period of greater than 4 weeks. There was also documentation of suggestion for knee surgery in 2011. He has failed conservative therapy and orthopedic consult is warranted

Twelve (12) physical therapy sessions for the bilateral knees: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints, Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99.

Decision rationale: Per the ACOEM: Instruction in proper exercise technique is important and a few visits to a physical therapist can serve to educate the patient about an effective exercise program. The clinician or therapist should teach the patient rehabilitation programs for knee problems. Per the California MTUS: Physical Medicine. Recommended as indicated below. Passive therapy (those treatment modalities that do not require energy expenditure on the part of the patient) can provide short term relief during the early phases of pain treatment and are directed at controlling symptoms such as pain, inflammation and swelling and to improve the rate of healing soft tissue injuries. They can be used sparingly with active therapies to help control swelling, pain and inflammation during the rehabilitation process. Active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. Active therapy requires an internal effort by the individual to complete a specific exercise or task. This form of therapy may require supervision from a therapist or medical provider such as verbal, visual and/or tactile instruction(s). Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. Home exercise can include exercise with or without mechanical assistance or resistance and functional activities with assistive devices. (Colorado, 2002) (Airaksinen, 2006) Patient-specific hand therapy is very important in reducing swelling, decreasing pain, and improving range of motion in CRPS. (Li, 2005) The use of active treatment modalities (e.g., exercise, education, activity modification) instead of passive treatments is associated with substantially better clinical outcomes. In a large case series of patients with low back pain treated by physical therapists, those adhering to guidelines for active rather than passive treatments incurred fewer treatment visits, cost less, and had less pain and less disability. The overall success rates were 64.7% among those adhering to the active treatment recommendations versus 36.5% for passive treatment. (Fritz, 2007) Physical Medicine Guidelines - Allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home Physical Medicine. This patient has documented failure to respond to previous physical therapy as well as failure to complete previously recommended physical therapy sessions. Additional physical therapy sessions do not meet guideline recommendations as outlined above and thus are non-certified.