MAXIMUS Federal Services

Case Number:	CM13-0043829		
Date Assigned:	12/27/2013	Date of Injury:	07/30/2008
Decision Date:	05/21/2014	UR Denial Date:	10/04/2013
Priority:	Standard	Application Received:	10/31/2013

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. The expert reviewer is Board Certified in Family Medicine and is licensed to practice in Arizona. 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/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 74-year-old worker with a date of injury on 7/30/2008. The injury resulted in internal derangement of the knee and discogenic lumbar condition, the latter followed by another physician. Subjective complaints are of knee pain described as 7/10, to 5-6/10 with medicine in December 2012; 7-8/10 to 4-5/10 March 2013; 8-10/10 to 4-5/10 April; and persistent at 8/10 in June when last reported. Physical exam shows knee flexion and extension unchanged, bilateral lower extremity strength of 4+/5 and antalgic gait. Treatment has included right knee arthroscopy and partial meniscectomy, brace, cold wraps, transcutaneous electric nerve stimulation (TENS) unit, injections, physical therapy, heat and cold applications and a cane.

IMR ISSUES, DECISIONS AND RATIONALES

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

TRAMADOL ER 150MG #30: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Tramadol and Opioids, Page(s): 93-94, 74-96.

Decision rationale: CA Chronic Pain Guidelines has specific recommendations for the ongoing management of opioid therapy. Clear evidence should be presented about the degree of

analgesia, level of activity of daily living, adverse side effects, or aberrant drug taking behavior. Failure to respond to a time-limited course of opioids leads to the suggestion of reassessment and consideration of alternative therapy. Tramadol is a synthetic opioid used for moderate to severe pain. It may increase the risk of seizure, especially in patients taking other opioids or selective serotonin reuptake inhibitors (SSRIs), and may induce life-threatening serotonin syndrome in patients taking SSRIs. This patient is documented as taking Paroxetine, and concurrent opioid therapy with Norco. For this patient, there is no documentation of efficacy with prior usage, not measurable decrease in patient's pain or increase in functional ability. For this patient, there is also no documentation present of MTUS opioid compliance guidelines, including risk assessment, attempt at weaning, updated urine drug screen, and ongoing efficacy of medication. Therefore, the use of this medication is not consistent with guidelines and the medical necessity is not established.

TRAZODONE 50MG #60: 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), Pain Chapter, Insomnia Treatment.

Decision rationale: ODG guidelines state that chronic insomnia may be correlated with other intrinsic sleep disorders, primary insomnia, or chronic medical condition and is more likely to occur in the elderly, depressed patients, and medically ill populations. Failure of sleep disturbance to resolve in a 7 to 10 day period may indicate a psychiatric and/or medical illness. Guidelines state that pharmacological agents should only be used after careful evaluation of potential causes of sleep disturbance. The record shows no evaluation for cause of the worker's insomnia. The ODG states that sedating antidepressants (e.g., amitriptyline, trazodone, mirtazapine) have also been used to treat insomnia; however, there is less evidence to support their use for insomnia, but they may be an option in patients with coexisting depression. This patient has a diagnosis of depression and is being treated with an antidepressant, and adding a second antidepressant is not clearly established in the medical record. Furthermore, the use of Trazodone for insomnia did not include documentation of ongoing efficacy or potential side effects. Therefore, the medical necessity of Trazodone is not established.

PRILOSEC 20MG #60: Overturned

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): 67-69.

Decision rationale: According to the CA MTUS guidelines, a proton pump inhibitor (PPI) or H2 blocker can be added to non-steroidal anti-inflammatory drug (NSAID) therapy if the patient is

at an intermediate to high risk for adverse gastrointestinal (GI) events. Guidelines identify the following as risk factors for GI events: age greater than 65, history of peptic ulcer, GI bleeding or perforation, use of acetylsalicylic acid (ASA), corticosteroids, anticoagulant use, or high dose NSAIDS. In the setting of dyspepsia, options are to stop or switch the NSAID or add a histamine-2 blocker or a proton pump inhibitor. For this patient, dyspepsia has been described secondary to his medication use. Therefore, the use of Prilosec is consistent with guidelines and is medically necessary.