

Case Number:	CM13-0045678		
Date Assigned:	12/27/2013	Date of Injury:	02/29/2008
Decision Date:	02/26/2014	UR Denial Date:	11/01/2013
Priority:	Standard	Application Received:	11/12/2013

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 Anesthesiology, has a subspecialty in Pain Management and is licensed to practice in Georgia. 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 57-year-old male presenting with low back pain and bilateral knee pain following a work-related injury on February 29, 2008. The claimant reported moderate to severe pain in the left more than the right knee. The pain is associated with occasional swelling and giving way. The pain is exacerbated by kneeling, squatting, twisting, and prolonged sitting. The physical exam was significant for tenderness along the medial joint line of the knee, flexion to 125°, limited flexibility of the lumbar spine, and tenderness at L2-3 with spasm. The claimant was diagnosed with chronic degenerative lumbar disc disease with massive disc herniation L4-5 as well as minor disc bulge L3, L4 and L5-S1, status post medial meniscectomy right and left the, advanced degenerative arthritis left knee tricompartmental, moderate bilateral chondromalacia patella, infectious obesity weighing 240 pounds. The claimant's medications include Anaprox 550 mg, Vicodin 500 mg, Prilosec 20 mg, Neurontin 300 mg, and transdermal cream.

IMR ISSUES, DECISIONS AND RATIONALES

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

Request for prescription of Anaprox 550mg #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): 72.

Decision rationale: Anaprox 550mg not medically necessary. Per MTUS guidelines page 67, NSAIDs are recommended for osteoarthritis at the lowest dose for the shortest period in patients with moderate to severe pain so to prevent or lower the risk of complications associate with cardiovascular disease and gastrointestinal distress. The medical records do no document the length of time the claimant has been on Anaprox or if there was any previous use of NSAIDs. The medication is therefore not medically necessary.

Request for prescription of Vicodin 500mg #60: 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 Opioids Page(s): 79.

Decision rationale: Vicodin 500mg one tablet by mouth every twelve hours as needed for pain is not medically necessary. Per MTUS Page 79 of MTUS guidelines states that weaning of opioids are recommended if (a) there are no overall improvement in function, unless there are extenuating circumstances (b) continuing pain with evidence of intolerable adverse effects (c) decrease in functioning (d) resolution of pain (e) if serious non-adherence is occurring (f) the patient requests discontinuing. The claimant's medical records did not document that there was an overall improvement in function or a return to work with previous opioid therapy. In fact, the medical records note that the claimant was permanent and stationary. The claimant has long-term use with this medication and there was a lack of improved function with this opioid; therefore, Vicodin is not medically necessary.

Request for prescription of Prilosec 20 mg #60: 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 NSAIDs Page(s): 67.

Decision rationale: Prilosec 20mg is not medically necessary. CA MTUS does not make a direct statement on proton pump inhibitors (PPI) but in the section on NSAID use page 67. Long-term use of PPI or misoprostol or Cox-2 selective agents have been shown to increase the risk of Hip fractures. CA MTUS does state that NSAIDs are not recommended for long-term use as well and if there possible GI effects of another line of agent should be used for example acetaminophen. Prilosec is therefore, not medically necessary.

Request for prescription of Neurontin 300mg #90: 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 AEDs Page(s): 16-17.

Decision rationale: Neurontin is not medically necessary. Page 17 of the CA MTUS states that there is insufficient evidence to recommend for or against anti-epileptic drugs for axial low back pain. In terms of neuropathic back pain, page 16 of the CA MTUS states that there was lack of expert consensus on the treatment of neuropathic pain in general due to heterogeneous etiologies, symptoms, physical signs and mechanisms. Most randomized controlled trials were also directed at central pain and none for painful radiculopathy. Given the claimant was not diagnosed with neuropathy or a qualifying condition; the request is not medically necessary.

Request for prescription for transdermal pain GKL: 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): 111-112.

Decision rationale: According to California MTUS, 2009, chronic pain, page 111 California MTUS guidelines does not cover "topical analgesics that are largely experimental in use with a few randomized controlled trials to determine efficacy or safety. Any compounded product that contains at least one drug or drug class that is not recommended is not recommended". Additionally, Per CA MTUS page 111 states that topical analgesics such as lidocaine are "recommended for localized peripheral pain after there has been evidence of a trial of first-line therapy (anti-depressants or AED)...Only FDA-approved products are currently recommended. Non-neuropathic pain: Not recommended. The claimant was not diagnosed with neuropathic pain and there is no documentation of physical findings or diagnostic imaging confirming the diagnosis. The claimant was diagnosed with lumbar sprain/strain, which is non-neuropathic pain syndrome. Per CA MTUS, topical analgesic such as Lidocaine is not recommended for non-neuropathic pain. Finally, in regards to Ketoprofen, which is a topical NSAID, MTUS guidelines indicates this medication for Osteoarthritis and tendinitis, in particular, that of the knee and elbow or other joints that are amenable to topical treatment. It is also recommended for short-term use (4-12 weeks). There is little evidence to utilize topical NSAIDs for treatment of pain associated with the spine, hip or shoulder; therefore, compounded topical cream is not medically necessary.

Request for initial chiropractic care sessions 2 times a week for 3 weeks for the low back and bilateral knees: 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 Manual Therapy Page(s): 58.

Decision rationale: Per CA MTUS, Chiropractor therapy is considered manual therapy. This therapy is recommended for chronic pain caused by musculoskeletal conditions. Manual therapy as well as the use in the treatment of muscular skeletal pain. The intended goal or effect of manual medicine is the achievement of positive symptomatic or objective measurable gains in functional improvement that facilitate progression in the patient's therapeutic exercise program and return to productive activities. Manipulation is manual therapy that moves a joint beyond the physiologic range of motion but not beyond the anatomic range of motion. For low back pain, manual therapy is recommended as an option. Therapeutic care requires a trial of six visits over 2 weeks, with evidence of objective functional improvement, total of up to 18 visits over 6-8 weeks. Elective maintenance care is not medically necessary. For recurrences/flare-ups the need to reevaluate treatment success, if return to work achieved then 1-2 visits every 4-6 months. Low back: Recommended as an option. Therapeutic care - Trial of 6 visits over 2 weeks, with evidence of objective functional improvement, total of up to 18 visits over 6-8 weeks. Elective/maintenance care - Not medically necessary. Recurrences/flare-ups - Need to reevaluate treatment success, if RTW achieved then 1-2 visits every 4-6 months. Ankle & Foot: Not recommended. Carpal tunnel syndrome: Not recommended. Forearm, Wrist, & Hand: Not recommended. Knee: Not recommended. A request for chiropractor therapy 2 times per week for 3 weeks does not meet CA MTUS guidelines. Chiropractor therapy is not recommended for knees and for back pain there must be a trial of 6 visits initial 2 weeks first; therefore the request is not medically necessary.