

Case Number:	CM13-0053888		
Date Assigned:	12/30/2013	Date of Injury:	12/31/2009
Decision Date:	06/05/2014	UR Denial Date:	11/08/2013
Priority:	Standard	Application Received:	11/18/2013

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 Physical Medicine and Rehabilitation and is licensed to practice in Texas. 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 injured worker is a 51 year-old female who is reported to have sustained injuries to the left knee and low back as the result of tripping on 12/31/09. The patient is status post left knee arthroscopy performed on 08/23/12. The patient was noted to have a history of a burst popliteal cyst. Postoperatively the patient had continued subjective complaints of pain and a recurrent popliteal cyst. Imaging studies indicate lumbar degenerative disease. The records indicate subjective complaints of knee pain, low back, and left lower extremity pain. Per clinical note dated 11/26/13 there is mild swelling in the knee bone which is reduced from a previous examination. Extension is to 170 and flexion is to 120 degrees. There is tenderness over the lumbar paraspinals. It is reported that the patient does not require any medications today. The request is for Flexeril 7.5 mg, Tramadol ER 150 mg, Effexor SR 75 mg, Protonix 20 mg, Trazadone 50 mg, Terocin Patches, Kidney and Liver function tests, and left knee standing x-ray for a 10/25/13 date of service.

IMR ISSUES, DECISIONS AND RATIONALES

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

FLEXERIL 7.5MG #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants Page(s): 63-66.

Decision rationale: The patient is a 51 year-old female with chronic low back pain in the presence of multi-level lumbar degenerative disease. Per the clinical note dated 11/26/13 the patient has tenderness over the lumbar paraspinal musculature. The records reflect that the patient has improved pain control and did not require medications on that date. The examination does not indicate the presence of active muscle spasm. The California Medical Treatment Utilization Schedule does not support the chronic use of muscle relaxants for the treatment of pain. Further noting the lack of objective findings on examination, the use of a muscle relaxant is not clinically indicated and therefore not medically necessary.

TRAMADOL ER 150MG #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines OPIOIDS Page(s): 74-80.

Decision rationale: The patient is a 51 year-old female who has chronic left knee and low back pain. The records indicate that the patient had improvement in her pain levels and functional status. When seen in follow-up on 11/26/13, the patient did not require any medications. This vague statement does not identify the duration of pain relief of medications. However, given the report the medical necessity for continued use of opiate medications has not been established. The records do not provide any data regarding compliance testing, Visual Analogue Scale (VAS) scores, or clear documentation of functional improvements while on this medication. As such the request does not meet California Medical Treatment Utilization Schedule treatment recommendations and medical necessity has not been established.

EFFEXOR SR 75MG #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines SSRIS (SELECTIVE SEROTONIN REUPTAKE INHIBITORS,).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines ANTIDEPRESSANTS Page(s): 13-18.

Decision rationale: The submitted clinical records indicate the patient has chronic knee and back pain. The patient has been largely maintained on oral medications. There are reports of comorbid depression. However, the records do not contain any data such as Beck Anxiety Inventory or Beck Depression Inventory (BAI or BDI) to substantiate the medical necessity for this medication. If used for neuropathic pain there is no evidence of decreased pain scores as result. Based on information provided the medical necessity is not established and previous determination is upheld.

PROTONIX 20MG #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS, GI SYMPTOMS & CARDIOVASULAR RISK.

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, Proton Pump Inhibitors.

Decision rationale: The submitted clinical records indicate the patient has a chronic pain syndrome and has been maintained on oral medications. The records provide no data to establish that the patient has medication induced gastritis. As such, the medical necessity is not established and the prior determinations are upheld.

TRAZODONE 50MG #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines ANTIDEPRESSANTS Page(s): 13-18.

Decision rationale: The submitted clinical records indicate the patient has chronic knee and back pain. The patient has been largely maintained on oral medications. There are reports of comorbid depression. However, the records do not contain any data such as Beck Anxiety Inventory or Beck Depression Inventory (BAI or BDI) to substantiate the medical necessity for this medication. If used for neuropathic pain there is no evidence of decreased pain scores as result. Based on information provided the medical necessity is not established and previous determination is upheld.

TEROCIN PATCHES #20: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TOPICAL ANALGESICS Page(s): 112-113.

Decision rationale: The submitted clinical records indicate the patient has a chronic pain syndrome secondary to left knee and low back pain. California Medical Treatment Utilization Schedule notes that topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. Primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. The record provides no data to establish the efficacy of this topical medication. As such, the medical necessity for continued use is not supported.

LABS: LIVER AND KIDNEY FUNCTION: Overturned

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS, GI SYMPTOMS & CARDIOVASULAR RISK Page(s): 67-73.

Decision rationale: The request for liver and kidney functions tests are recommended as medically necessary. The submitted records indicate the patient has a chronic pain syndrome that has been managed with oral medications. California Medical Treatment Utilization Schedule supports the performance of renal and hepatic function tests on patients who are chronically maintained on oral medications to prevent a loss of renal and/or hepatic function.

RETROSPECTIVE LEFT KNEE STANDING X-RAY FOR (DOS 10/25/2013): Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee Chapter, Radiography.

Decision rationale: The patient is a 51 year-old female who is status post knee surgery with chronic pain. On examination the patient has significant limitations in range of motion and popliteal fossa fullness. The requested radiograph is medically necessary to perform an assessment of the knee and must be performed prior to consideration of the more advanced imaging studies. As such, the medical necessity of the request is established and the prior determination is overturned.