

Case Number:	CM13-0065731		
Date Assigned:	01/03/2014	Date of Injury:	01/14/2007
Decision Date:	03/24/2014	UR Denial Date:	11/27/2013
Priority:	Standard	Application Received:	12/13/2013

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 Acupuncture & Pain Medicine 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:

This 54 year old male injured worker with date of injury 1/14/07 with related swelling and pain in the right knee. He is diagnosed with lumbosacral radiculopathy with disc protrusions and nerve damage; left knee femoral condyle osteonecrosis; and right knee pain due to overuse injury. He is status post left knee arthroscopy. 10/15/13 exam shows asymmetric Range of Motion (ROM), diminished ROM, femoral condyle tenderness, increased crepitus and popliteal cyst. Left knee MR arthrogram dated 8/13/09 revealed contusion, impaction, and bone edema; sprain and scarring of the proximal anterior greater than posterior cruciate ligaments; MCL scarring; as well as chondral thinning and fissuring. MRI of the left knee dated 4/23/12 revealed increased signal within the tibia and femoral epiphysis suggestive of osteonecrosis; and chondromalacia of the medial femoral condyle and patellofemoral joint. His treatment history includes medications, activity restrictions, bone growth stimulator, physical therapy, HEP, and surgery. The date of Utilization Review (UR) decision was 11/27/13.

IMR ISSUES, DECISIONS AND RATIONALES

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

Prilosec 20mg tablet #30: Overturned

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, GI symptoms & cardiovascular risk Page(s): 68.

Decision rationale: The MTUS Chronic Pain Medical Treatment Guidelines recommend the use of proton pump inhibitors in conjunction with NSAIDs in situations in which the patient is at risk for gastrointestinal events including: (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). CPMTG guidelines further specify: "Recommendations: Patients with no risk factor and no cardiovascular disease: Non-selective NSAIDs OK (e.g. ibuprofen, naproxen, etc.) Patients at intermediate risk for gastrointestinal events and no cardiovascular disease: (1) A non-selective NSAID with either a PPI (Proton Pump Inhibitor, for example, 20 mg omeprazole daily) or misoprostol (200 µg four times daily) or (2) a Cox-2 selective agent. Long-term PPI use (> 1 year) has been shown to increase the risk of hip fracture (adjusted odds ratio 1.44). Patients at high risk for gastrointestinal events with no cardiovascular disease: A Cox-2 selective agent plus a PPI if absolutely necessary. Patients at high risk of gastrointestinal events with cardiovascular disease: If GI risk is high the suggestion is for a low-dose Cox-2 plus low dose Aspirin (for cardioprotection) and a PPI. If cardiovascular risk is greater than GI risk the suggestion is naproxyn plus low-dose aspirin plus a PPI. (Laine, 2006) (Scholmerich, 2006) (Nielsen, 2006) (Chan, 2004) (Gold, 2007) (Laine, 2007)" Per 07/2/13 report, the injured worker was noted to have an ulcer. A history of peptic ulcer while currently being treated with an NSAID (Anaprox) is a criteria to be treated with this medication. The request is medically necessary. Of note, this was approved by the UR physician and therefore is not in dispute.

Ultram 150mg Tablet #60: Overturned

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 and 93.

Decision rationale: According to MTUS CPMTG p93, Tramadol (Ultram) is a synthetic opioid affecting the central nervous system. Tramadol is not classified as a controlled substance by the DEA. Per p94, Tramadol is indicated for moderate to severe pain. This is a new medication. I respectfully disagree with the UR physician's assertion that there is any risk of suicide or addiction. The request is medically necessary.

Anaprox 550mg Tablet #30: Overturned

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: The MTUS CPMTG states with regard to NSAIDs and 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." While this injured worker is not diagnosed with osteoarthritis, he is significant for knee pathology. Per 10/15/13 report, his knee pain is 5+/10 at rest and 7-8/10 with activity or squatting. He is concurrently treated with Prilosec and has stated "I am worse without the meds - I do not have an ulcer and I am better and came to restart meds". The request is medically necessary.

Norco 10/325mg Tablet #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 and 91.

Decision rationale: Per MTUS Chronic Pain Medical Treatment Guidelines p78 regarding ongoing management of opioids "Four domains have been proposed as most relevant for ongoing monitoring of chronic pain patients on opioids: Pain relief, side effects, physical and psychosocial functioning, and the occurrence of any potentially aberrant (or nonadherent) drug related behaviors. These domains have been summarized as the '4 A's' (Analgesia, activities of daily living, adverse side effects, and any aberrant drug-taking behaviors). The monitoring of these outcomes over time should affect therapeutic decisions and provide a framework for documentation of the clinical use of these controlled drugs." Review of the available medical records reveal neither documentation to support the medical necessity of Norco nor any documentation addressing the '4 A's' domains, which is a recommended practice for the on-going management of opioids. It is noted that per 7/6/11 report, the injured worker was taking Norco, it is unclear however, whether its use was ongoing. Additionally, the notes do not appropriately review and document pain relief, functional status improvement, appropriate medication use, or side effects. The MTUS considers this list of criteria for initiation and continuation of opioids in the context of efficacy required to substantiate medical necessity, and they do not appear to have been addressed by the treating physician in the documentation available for review. Furthermore, efforts to rule out aberrant behavior (e.g. CURES report, UDS, opiate agreement) are necessary to assure safe usage and establish medical necessity. There is no documentation comprehensively addressing this concern in the records available for my review. The request is not medically necessary.