

Case Number:	CM13-0071961		
Date Assigned:	01/08/2014	Date of Injury:	05/10/2001
Decision Date:	06/05/2014	UR Denial Date:	12/02/2013
Priority:	Standard	Application Received:	12/30/2013

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 & Rehabilitation, 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 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 43 year old female who reported an injury on 05/10/2001 secondary to a trip and fall. She was evaluated on 11/22/2013 and reported increased left knee pain and 6/10 low back pain radiating to the lower extremities bilaterally which increased to 10/10 without medications. She also reported that she could perform the activities of bathing and dressing with the use of medications. On physical exam, the injured worker was noted to have a positive straight leg raise bilaterally, severe tenderness over the sacroiliac joint, and a positive Yeoman's test. She was also noted to have severe tenderness and limited range of motion of the left knee. The injured worker was diagnosed with left knee osteoarthritis, bilateral knee pain, and lumbar radiculopathy. Medications were noted to include Lansoprazole 30mg, Tramadol HCL 50mg, Cyclobenzaprine 10mg, Celebrex 200mg, Cymbalta 30mg, Senna 8.6mg, Hydrocodone/Acetaminophen 7.5/325mg, and Lidoderm 5% patches. A urine drug screen on 10/28/2013 was consistent with those medications, and the injured worker reported no side effects with continued use. She was previously treated with a steroid injection to the left knee on 07/03/2013 which helped to control the knee pain by 85% for 2 months. She also completed at least 40 sessions of physical therapy according to the documentation provided. It was noted that she underwent 2 left knee arthroscopic surgeries on unknown dates. A retrospective request for authorization was submitted on 11/22/2013 for Lansoprazole 30mg, Tramadol HCL 50mg, Cyclobenzaprine 10mg, Celebrex 200mg, Cymbalta 30mg, Senna 8.6mg, Hydrocodone/Acetaminophen 7.5/325mg, and Lidoderm 5% patches.

IMR ISSUES, DECISIONS AND RATIONALES

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

RETROSPECTIVE REQUEST FOR LANSOPRAZOLE CAP 30MG DR: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Proton Pump Inhibitors

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Nsaids, Gi Symptoms & Cardiovascular Risk Page(s): 68.

Decision rationale: The request for retrospective review of Lansoprazole 30mg is not medically necessary. California MTUS Guidelines do not recommend prophylactic use of a proton pump inhibitor such as Lansoprazole unless there is evidence that the injured worker is at high risk for gastrointestinal events. These risks included age greater than 65, history of peptic ulcer, GI bleeding or perforation, and concurrent use of aspirin, corticosteroids, and/or anticoagulants. There is a lack of documented evidence that the injured worker has a history of peptic ulcer, GI bleeding or perforation, and the clinical note at the time of the request stated that the injured worker did not experience any medication side effects. Therefore, treatment with a proton pump inhibitor is not supported by evidence-based guidelines. As such, the request is not medically necessary.

RETROSPECTIVE REQUEST FOR TRAMADOL HCL TAB 50MG: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Criteria For Use Page(s): 78.

Decision rationale: The retrospective request for Tramadol HCL tab 50mg is not medically necessary. California MTUS Guidelines recommend ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects in order to warrant continued opioid use. The documentation at the time of the request does include quantifiable pain relief from 10/10 to 6/10, improvement in activities of daily living, a recent and appropriate urine drug screen, and absence of side effects. However, the request as written does not include a frequency or quantity. Therefore, it is unclear if the amount of medication provided will allow for timely reassessment of the criteria for continued use. As such, the request is not medically necessary.

RETROSPECTIVE REQUEST FOR CYCLOBENZAPRINE TAB 10MG: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants (For Pain) Page(s): 63-64.

Decision rationale: The request for retrospective request for Cyclobenzaprine tab 10mg is not medically necessary. California MTUS Guidelines recommend Cyclobenzaprine as a short course of therapy with a duration of use no greater than 2-3 weeks. Guidelines also state that efficacy appears to diminish over time, and prolonged use may lead to dependence. The injured worker has used this medication since at least 05/10/2013 according to the documentation submitted for review. This duration is excessive according to evidence-based guidelines. Furthermore, the request as written does not include a frequency or quantity. As such, the request is not medically necessary.

RETROSPECTIVE REQUEST FOR CELEBREX CAP 200MG: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs (non-steroidal anti-inflammatory drugs),.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs (non-steroidal anti-inflammatory drugs) Page(s): 67.

Decision rationale: The retrospective request for Celebrex cap 200mg is not medically necessary. California MTUS Guidelines recommend that the lowest effective dose be used for all NSAIDs for the shortest duration of time consistent with the individual patient treatment goals. Guidelines also state that there is no evidence of long-term effectiveness for pain or function. The documentation submitted for review indicates that the injured worker has used Celebrex since at least 05/10/2013. Though the injured worker reported quantifiable pain relief and improved function with medications, this duration of use may not be supported by the guidelines. Furthermore, the request as written does not include a frequency or quantity. Therefore, it is unclear if the requested amount allows for ongoing reassessment of medication efficacy. As such, the request is not medically necessary.

RETROSPECTIVE REQUEST FOR CYMBALTA CAP 30MG: 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 Antidepressants For Chronic Pain Page(s): 15.

Decision rationale: The retrospective request for Cymbalta cap 30mg is not medically necessary. California MTUS Guidelines state that there is no high quality evidence to support the use of Cymbalta for lumbar radiculopathy. The injured worker did report quantifiable pain relief and improved functional ability with the use of her current medication regimen. However, the request as written does not include a frequency or quantity. Therefore, it is unclear if the requested amount allows for ongoing reassessment of medication efficacy. As such, the request is not medically necessary.

RETROSPECTIVE REQUEST FOR SENNA TAB 8.6MG: 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, Criteria For Use Page(s): 77.

Decision rationale: The retrospective request for Senna tab 8.6mg is not medically necessary. California MTUS Guidelines recommend prophylactic treatment of constipation with concurrent use of opioids. The injured worker was noted to be using prescribed opioids at the time of the request. However, the request as written does not include a frequency or quantity for medication use. As such, the request is not medically necessary.

RETROSPECTIVE REQUEST FOR HYDROCODONE/APAP TAB 7.5-325MG: 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, Criteria For Use Page(s): 78.

Decision rationale: The retrospective request for Hydrocodone/APAP tab 7.5/325mg is not medically necessary. California MTUS Guidelines recommend ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects in order to warrant continued opioid use. The documentation at the time of the request does include quantifiable pain relief from 10/10 to 6/10, improvement in activities of daily living, a recent and appropriate urine drug screen, and absence of side effects. However, the request as written does not include a frequency or quantity. Therefore, it is unclear if the amount of medication provided will allow for timely reassessment of the criteria for continued use. As such, the request is not medically necessary.

RETROSPECTIVE REQUEST FOR LIDODERM DIS 5%: 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): 112.

Decision rationale: The retrospective request for Lidoderm 5% is not medically necessary. California MTUS guidelines recommend Lidoderm for neuropathic pain. The injured worker reported low back pain radiating to the extremities. She also reported pain relief from 10/10 to 6/10 with medications as well as increased ability to perform activities of daily living with medications. However, the request as written does not include a frequency or quantity. Therefore, it is unclear if the requested amount allows for ongoing reassessment of medication efficacy. As such, the request is not medically necessary.

