

Case Number:	CM14-0012212		
Date Assigned:	02/21/2014	Date of Injury:	05/22/2013
Decision Date:	12/17/2014	UR Denial Date:	01/14/2014
Priority:	Standard	Application Received:	01/30/2014

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 Internal Medicine and is licensed to practice in District of Columbia and Virginia. 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:

This 50 year old male sustained a work related injury to the left knee on 03/09/2011. According to an Agreed Medical Evaluation (AME) performed on 06/05/2013, the injury occurred on 03/19/2011 when the injured worker slipped and fell on the left knee during the course of his usual duties as a hotel auditor and front desk agent. According to the AME, the injured worker underwent a left knee arthroscopic procedure on 12/10/2012 that revealed a grade IV osteochondral lesion of the left knee. This surgical report was not submitted for review. Documentation of radiographic imaging was also not submitted for review. He remained temporarily totally disabled. His medication regimen at the time evaluation was on an as needed basis and included Cardiovisc, Dyflonic, Tylenol, Hydrocodone and Tramadol. He complained of bilateral knee pain that was described as a constant throbbing pain in the left knee and a "knot" sensation in the right knee that had increased since his prior examination. As of an office visit on 10/09/2013, the injured worker complained of persistent left knee pain and continued swelling. A physical examination revealed well healed arthroscopic portals of the left knee. There was tenderness about the joint line. He could extend to 0 degrees and flex to 120 degrees. The Homan maneuver was negative. The calf was not tender to palpation. Crutches were used for ambulation. Diagnoses included left knee full thickness grade IV left femoral osteochondral lesion status post arthroscopy 12/10/2012, right knee strain and stress syndrome. The treatment plan included left knee surgery, Norco for break through pain, Ultram and an orthopaedic re-evaluation in six weeks. The injured worker remained temporarily totally disabled.

IMR ISSUES, DECISIONS AND RATIONALES

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

RANDOM URINE SAMPLE: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: CHRONIC PAIN, ,

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 88,89, 93, 94.

Decision rationale: As per MTUS guidelines, Urine drug testing should be done 2 times per year and the frequency can be increased if there are signs of abuse or addiction. Indicators and predictors of possible misuse of controlled substances and/or addiction: 1) Adverse consequences: (a) Decreased functioning, (b) Observed intoxication, (c) Negative affective state 2) Impaired control over medication use: (a) Failure to bring in unused medications, (b) Dose escalation without approval of the prescribing doctor, (c) Requests for early prescription refills, (d) Reports of lost or stolen prescriptions, (e) Unscheduled clinic appointments in "distress", (f) Frequent visits to the ED, (g) Family reports of overuse of intoxication 3) Craving and preoccupation: (a) Non-compliance with other treatment modalities, (b) Failure to keep appointments, (c) No interest in rehabilitation, only in symptom control, (d) No relief of pain or improved function with opioid therapy, (e) Overwhelming focus on opiate issues. 4) Adverse behavior: (a) Selling prescription drugs, (b) Forging prescriptions, (c) Stealing drugs, (d) Using prescription drugs in ways other than prescribed (such as injecting oral formulations), (e) Concurrent use of alcohol or other illicit drugs (as detected on urine screens), (f) Obtaining prescription drugs from non-medical sources (Wisconsin, 2004) (Michna, 2004) (Chabal, 1997) (Portenoy, 1997). Based on the clinical documentation provided, urine drug testing would be reasonable as the patient was prescribed opiates and did not have more than 2 urine drug tests in a year, the maximum allotted, per MTUS, for regular screening. Therefore the request is medically necessary.

VICODIN 5/500MG, #60: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: CHRONIC PAIN- OPIOIDS, ,

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 51,74 75,91.

Decision rationale: Per MTUS, Hydrocodone is a semi-synthetic opioid which is considered the most potent oral opioid that does not require special documentation for prescribing in some states (not including California). See Opioids. Hydrocodone/Acetaminophen (Anexsia, Co-Gesic, HycetTM; Lorcet, Lortab; Margesic-H, MaxidoneTM; Norco, Stagesic, Vicodin, Xodol, Zydone; generics available): Indicated for moderate to moderately severe pain. Note: there are no FDA-approved hydrocodone products for pain unless formulated as a combination. Side Effects: See opioid adverse effects. Analgesic dose: The usual dose of 5/500mg is 1 or 2 tablets PO every four to six hours as needed for pain (Max 8 tablets/day). For higher doses of hydrocodone (>5mg/tab) and acetaminophen (>500mg/tab) the recommended dose is usually 1 tablet every

four to six hours as needed for pain. Hydrocodone has a recommended maximum dose of 60mg/24 hours. The dose is limited by the dosage of acetaminophen, which should not exceed 4g/24 hours. The patient did not have documented improvement with this medication and this would not be further indicated. Therefore the request is not medically necessary.

FEXMID 7.5MG, #60: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: CHRONIC PAIN- MUSCLE RELAXANTS, ,

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 41-42, 64.

Decision rationale: Per MTUS, Cyclobenzaprine (Flexeril, Amrix, FexmidTM, generic available): Recommended for a short course of therapy. Limited, mixed-evidence does not allow for a recommendation for chronic use. Cyclobenzaprine is a skeletal muscle relaxant and a central nervous system depressant with similar effects to tricyclic antidepressants (e.g. amitriptyline). Cyclobenzaprine is more effective than placebo in the management of back pain, although the effect is modest and comes at the price of adverse effects. It has a central mechanism of action, but it is not effective in treating spasticity from cerebral palsy or spinal cord disease. Cyclobenzaprine is associated with a number needed to treat of 3 at 2 weeks for symptom improvement. The greatest effect appears to be in the first 4 days of treatment. (Browning, 2001) (Kinkade, 2007) (Toth, 2004) See Cyclobenzaprine. Cyclobenzaprine has been shown to produce a modest benefit in treatment of fibromyalgia. Cyclobenzaprine-treated patients with fibromyalgia were 3 times more likely to report overall improvement and to report moderate reductions in individual symptoms (particularly sleep). A meta-analysis concluded that the number needed to treat for patients with fibromyalgia was 4.8. (ICSI, 2007) (Tofferi, 2004) Side Effects: Include anticholinergic effects (drowsiness, urinary retention and dry mouth). Sedative effects may limit use. Headache has been noted. This medication should be avoided in patients with arrhythmias, heart block, heart failure and recent myocardial infarction. Side effects limit use in the elderly. (See, 2008) (Toth, 2004) Dosing: 5 mg three times a day. Can be increased to 10 mg three times a day. This medication is not recommended to be used for longer than 2-3 weeks. (See, 2008) Per guidelines, this medication should not be used as the time frame for which it was utilized is unclear from the documentation provided. Therefore the request is not medically necessary.