

Case Number:	CM14-0020327		
Date Assigned:	04/25/2014	Date of Injury:	09/12/2004
Decision Date:	07/18/2014	UR Denial Date:	01/27/2014
Priority:	Standard	Application Received:	02/18/2014

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 Occupational 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 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 patient is a 52-year-old male who has submitted a claim for right knee pain, right knee osteoarthritis and right knee internal derangement associated with an industrial injury date of September 12, 2004. Medical records from 2013 through 2014 were reviewed, which showed that the patient complained of chronic right knee pain which would occasionally radiate to his right anterior shin region. Prolonged standing and walking would exacerbate the pain. Physical examination showed that right knee ranges of motion were restricted by pain in all directions. Right knee provocative maneuvers were positive. Nerve root tension signs were negative bilaterally. Clonus, Babinski's and Hoffman's signs were absent bilaterally. Muscle strength was 5/5 in all limbs bilaterally. Treatment to date has included right knee surgery x3, and medications, which include Zantac 150mg, Vicodin 5mg, Ibuprofen 600mg, Theracodophen-Low-90, Gabapentine, Pennsaid, Norco 10/325, MS Contin, and Celebrex 200mg. Utilization review from January 27, 2014 did not grant the request for Celebrex 200 mg #30 because guidelines do not support chronic use of anti-inflammatories for osteoarthritis. There was also no detailing of intermediate gastrointestinal risk factors necessitating use of Celebrex rather than a non-selective NSAID agent. The request for Hydrocodone 10/325 #90 with 3 refills was not granted because reports did not document efficacy of opioid use and functional improvements in activities of daily living. Pain benefits were not evident and it was also unclear that this was the lowest dosing. The medical necessity was not established for its use. Another utilization review from April 3, 2014 approved Celebrex 200mg #30 and Hydrocodone 10/325mg #90.

IMR ISSUES, DECISIONS AND RATIONALES

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

HYDROCODONE 10/325MG, #90 WITH 3 REFILLS: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 74-82.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 78-81.

Decision rationale: According to pages 78-81 of the California MTUS Chronic Pain Medical Treatment Guidelines, ongoing opioid treatment is not supported unless prescribed, at the lowest possible dose and unless there is ongoing review and documentation, of pain relief, functional status, appropriate medication use, and side effects. The monitoring of these outcomes over time should affect therapeutic decision and provide a framework for documentation of the clinical use of these controlled drugs. In this case, the medical records, specifically a progress report dated 2/14/14, clearly mentioned continued analgesia and functional benefit, and not enough of adverse effects or aberrant behavior from hydrocodone use. It also stated that hydrocodone use has enabled the patient to work full time full duty. The medical necessity has been established. Therefore, the request for Hydrocodone 10/325mg, #90 with 3 refills is medically necessary.

CELEBREX 200 MG: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 22, 67.

Decision rationale: According to page 22 of the Chronic Pain Medical Treatment Guidelines, NSAIDs are recommended at the lowest dose for the shortest period in patients with moderate to severe pain, and that Celebrex may be considered if the patient has a risk of GI complications, but not for the majority of patients. In addition, guidelines state that anti-inflammatory is the traditional first line of treatment to reduce pain but long-term use may not be warranted. In this case, medical records mentioned that Celebrex use provided 50% improvement of inflammatory pain with maintenance of his activities of daily living. Records also stated that the patient was unable to tolerate Ibuprofen and other non-specific COX inhibitors due to GERD and GI upset. Although, medical necessity has been established, the request did not specify the number to be dispensed. Therefore, the request for Celebrex 200mg is not medically necessary.