

Case Number:	CM14-0051735		
Date Assigned:	07/07/2014	Date of Injury:	01/18/2012
Decision Date:	08/29/2014	UR Denial Date:	04/01/2014
Priority:	Standard	Application Received:	04/19/2014

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 Physical Medicine and 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 45-year-old male who reported an injury on 01/18/2012. The mechanism of injury was not provided within the medical records. The clinical note dated 03/14/2014 indicated diagnosis of bilateral knee arthritis. The injured worker reported ongoing left knee pain with some relief with the 2 Orthovisc injections. The injured worker reported his right knee was progressively getting worse. On physical examination of the lower extremities the left knee demonstrated limited range of motion with crepitance and a 1+ effusion. The right knee demonstrated healed arthroscopic portals, slight various crepitance throughout range of motion, 1+ effusion and a palpable Baker's cyst. The injured worker ambulated with a bilateral antalgic gait. The injured worker's treatment plan included a third Orthovisc injection into his left knee, an MRI of the left knee, medications and follow-up. The injured worker's prior treatments included diagnostic imaging and injections and medications. The injured worker's medication regimen included Protonix, Anaprox, tramadol and Lorcet Plus. The provider submitted a request for retro tramadol, retro Lorcet Plus and retro Protonix. A Request for Authorization dated 03/14/2014 was submitted for tramadol, Lorcet, and Protonix; however, a rationale was not provided for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

RETRO Tramadol 150 mg, #30, one tab daily, no refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Tramadol (Ultram) Page(s): 93-94.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Tramadol (Ultram) Page(s): 113.

Decision rationale: The request for RETRO Tramadol 150 mg, #30, one tab daily, no refills is not medically necessary. The California MTUS guidelines state tramadol (Ultram) is a centrally acting synthetic opioid analgesic and it is not recommended as a first-line oral analgesic. There is lack of documentation of efficacy and functional improvement with the use of this medication. In addition, the request for retro did not indicate a retro date. Moreover, it was not indicated if the injured worker had tried a first line analgesic. Additionally, it was not indicated how long the injured worker had been utilizing the tramadol. Therefore, the request for tramadol is not medically necessary.

RETRO Lorcet Plus 7.5//650 mg, #60, one tab twice a day, no refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Hydrocodone/Acetaminophen Page(s): 91.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use Page(s): 78.

Decision rationale: The request for Lorcet Plus 7.5//650 mg, #60, one tab twice a day, no refills is not medically necessary. The California MTUS Guidelines recommend the use of opioids for the on-going management of chronic low back pain. The ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects should be evident. There is lack of documentation of efficacy and functional improvement with the use of this medication. In addition, there is lack of a pain assessment by the injured worker. Moreover, it was not indicated how long the injured worker had been utilizing this medication. In addition, the request did not indicate a retro date. Therefore, the request is not medically necessary.

RETRO Protonix 20 mg, #90, one tab twice a day, no refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI Symptoms and Cardiovascular Risk Page(s): 68-69.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk Page(s): 68.

Decision rationale: The request for RETRO Protonix 20 mg, #90, one tab twice a day, no refills is not medically necessary. The CA MTUS guidelines recommend the use of proton pump inhibitors if there is a history of gastrointestinal bleeding or perforations, a prescribed high dose of NSAIDs and a history of peptic ulcers. There is also a risk with long-term utilization of PPI (> 1 year) which has been shown to increase the risk of hip fracture. There is lack of documentation of efficacy and functional improvement with the use of the medication. In

addition, the documentation submitted did not indicate the injured worker had findings that would support he was at risk for gastrointestinal bleeding or perforations or peptic ulcers. Additionally, the request did not indicate a date for the retro date. Therefore, the request for Protonix is not medically necessary.