

Case Number:	CM14-0065462		
Date Assigned:	07/11/2014	Date of Injury:	05/07/2003
Decision Date:	09/17/2014	UR Denial Date:	04/10/2014
Priority:	Standard	Application Received:	05/08/2014

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 Illinois. 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 41-year-old male who reported an injury 05/07/2013. The mechanism of injury was not provided within the medical records. The clinic note dated 07/02/2014 indicated a diagnosis of osteoarthritis of the left leg, shoulder sprain/strain. The injured worker reported right shoulder pain and reported right shoulder surgery had been authorized. The injured worker reported left knee pain. The injured worker reported pain to his right shoulder, activity, pain with compression and with range of motion, moderate weakness. The injured worker reported knee pain that was localized to the left anterior knee, the left lateral knee and the left medial knee and the left posterior knee. The injured worker reported pain with activity, compression pain and range of motion. The injured worker described his knee pain as moderate that was aggravated by bending, extension of the knee, climbing stairs, descending stairs and going from a seated position, squatting, recreational activities, running and regular walking. Physical examination of the right shoulder, the injured worker had subacromial tenderness present and bicipital groove tenderness. The injured worker's right shoulder range of motion was decreased. Supraspinatus strength was 4/5. The injured worker had a positive crossover, positive Hawkin's, positive impingement, positive O'Brien's and positive Speed's test. The examination of the left knee revealed mild patellofemoral joint crepitation and mild anterior medial joint line tenderness with mild lateral patella tenderness. The injured worker's left knee range of motion was decreased and the injured worker had a positive medial McMurray, positive patellar compression test and positive patellar crepitation test. The injured worker's treatment plan included an injection, schedule surgery, home exercise program. The injured worker's prior treatments included diagnostic imaging and medication management. The injured worker's medication regimen included nortriptyline, Wellbutrin, Nexium, Fibercon, Zoloft, Butrans, Ultram, Cialis, Voltaren and Celebrex. The provider submitted a request for lorazepam, Nexium, Cialis and Flector. A

Request for Authorization was not submitted for review to include the date the treatment was requested.

IMR ISSUES, DECISIONS AND RATIONALES

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

LORAZEPAM TAB 0.5MG DAY SUPPLY: 30 QTY: 60 REFILLS: 03: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

Decision rationale: The request for LORAZEPAM TAB 0.5MG DAY SUPPLY: 30 QTY: 60 REFILLS: 03 is not medically necessary. The Official Disability Guidelines state Lorazepam is not recommended for long-term use because long-term efficacy is unproven and there is a risk of psychological and physical dependence or frank addiction. Most guidelines limit use to 4 weeks. Benzodiazepines are a major cause of overdose, particularly as they act synergistically with other drugs such as opioids (mixed overdoses are often a cause of fatalities). It was not indicated if this was for a first time trial or if the injured worker had been utilizing lorazepam. However, the provider did not indicate a rationale for the request. Moreover, if the injured worker had been utilizing lorazepam there is lack of documentation of efficacy and functional improvement with the use of this medication. Additionally, the request did not indicate a frequency. Therefore, the request for lorazepam is not medically necessary.

NEXIUM CAP 40MG DAY SUPPLY: 30 QTY: 30 REFILLS: 04: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain, Nexium.

Decision rationale: The request for NEXIUM CAP 40MG DAY SUPPLY: 30 QTY: 30 REFILLS: 04 is not medically necessary. The Official Disability 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. The guidelines also state a trial of omeprazole or lansoprazole is recommended before Nexium therapy. The documentation submitted did not indicate the injured worker had findings that would support he was at risk for gastrointestinal bleeding, perforations or peptic ulcers. In addition, there was lack of documentation of efficacy and functional improvement with the use of this medication. Moreover, it was not indicated the injured worker had tried omeprazole or lansoprazole prior to the use of Nexium. Additionally, the request did not indicate a frequency. Therefore, the request is not medically necessary.

CIALIS TAB 20MG DAY SUPPLY: 5 QTY: 5 REFILLS: 04: 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 Testosterone replacement for hypogonadism (related to opioids) Page(s): 110.

Decision rationale: The request for CIALIS TAB 20MG DAY SUPPLY: 5 QTY: 5 REFILLS: 04 is not medically necessary. The California MTUS guidelines state hypogonadism secondary to opiates appears to be central, although the exact mechanism has not been determined. Routine testing of testosterone levels in men taking opioids is not recommended; however, an endocrine evaluation and/or testosterone levels should be considered in men who are taking long term, high dose oral opioids or intrathecal opioids and who exhibit symptoms or signs of hypogonadism, such as gynecomastia. There is lack of documentation of efficacy and functional improvement with the use of Cialis. In addition, it was not indicated if the injured worker had an endocrine evaluation or testosterone level obtained. Moreover, the request does not indicate a frequency for the medication. Therefore, the request is not medically necessary.

FLECTOR DIS 1.3% DAY SUPPLY: 30 QTY: 60 REFILLS: 02: 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).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Flector patches Topical Analgesics, Topical NSAIDs Page(s): 111.

Decision rationale: The request for FLECTOR DIS 1.3% DAY SUPPLY: 30 QTY: 60 REFILLS: 02 is not medically necessary. The California MTUS guidelines indicate that topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. Primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. The guidelines also state any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. The guidelines indicate that Topical NSAIDs have been shown in meta-analysis to be superior to placebo during the first 2 weeks of treatment for osteoarthritis, but either not afterward, or with a diminishing effect over another 2-week period. The indications for the use of topical NSAIDs are osteoarthritis and tendinitis of the knee and other joints that can be treated topically. They are recommended for short term use of 4-12 weeks. There is little evidence indicating effectiveness for treatment of osteoarthritis of the spine, hip or shoulder. The documentation submitted indicates the injured worker is utilizing the Voltaren transdermal gel. It is not indicated why the injured worker would need the Flector patch or gel. Additionally, the provider did not indicate a rationale for the request. The request does not indicate a frequency for this medication. In addition, it was not indicated if the injured worker had tried and failed antidepressants or anticonvulsants. Therefore, the request for Flector is not medically necessary.