

Case Number:	CM14-0198825		
Date Assigned:	12/09/2014	Date of Injury:	07/21/2009
Decision Date:	01/26/2015	UR Denial Date:	10/28/2014
Priority:	Standard	Application Received:	11/26/2014

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 Family Practice 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:

This 59-year old office assistant reported multiple injuries due to several falls at work, the earliest of which occurred on 7/21/09. She also reinjured her left ankle while stepping off a curb on the way to the doctor's office on 7/19/14. In addition, she has apparently claimed overuse injuries due to her usual work duties. Injured body parts include the neck, the right shoulder, right elbow and wrist, both knees, and the left ankle. Surgeries have included a C3-7 laminectomy, right shoulder arthroscopy, a right wrist carpal tunnel release, a right wrist surgery for De Quervain's tenosynovitis, arthroscopy of the left knee and 2 arthroscopies of the right knee, the most recent of which was performed on 6/30/14. The records reveal that the patient has been taking Tramadol, Cyclobenzaprine and Lorazepam since at least 1/16/14, which is the earliest progress note in the available records. Hydrocodone/APAP appears to have been first prescribed in July 2014 and has been continued to the present. According to the primary physician's progress note of 10/6/14 the patient continues to have constant mid and low back pain, hip and thigh pain, and left knee and ankle pain. She is unable to put weight on her left ankle. Documented objective findings include only tenderness of the lateral left ankle. Diagnoses include musculoligamentous sprain lumbar sacral spine with right extremity radiculitis, lateral ligament injury of the left ankle, peroneal tendon injury of the left ankle, internal derangement of the left knee with possible meniscal tear, prior avulsion fracture of the left ankle lateral malleolus, left heel spur, previous excision of left knee cyst, prior left knee medial meniscal tear, osteoarthritis of the left knee, and multiple disc bulges of the thoracic and lumbar spine. The treatment plan includes continuation of Lorazepam, Cyclobenzaprine and Tramadol, awaiting authorization for consultation with an ankle specialist, and physical therapy twice per week for 8 sessions. The 10/15/14 note from the same provider documents similar complaints with the addition of neck and right knee pain. The patient can walk for up to 15 minutes before having to

rest due to ankle pain. The plan is similar, but includes continuing Hydrocodone/APAP in addition to Tramadol, Cyclobenzaprine and Lorazepam. The records continue a report of an MRI of the left ankle performed 12/20/13 which notes osteoarthritis of the ankle mortise and posterior subtalar joints, plantar and dorsal heel spurs, tendinosis of the peroneus longus and brevis and of the tibialis posterior tendon, and non-visualization of the anterior distal talofibular ligament, with the implication that a tear could not be excluded. The records contain documentation of 8 previous physical therapy sessions for the ankle from 7/2/14 through 8/22/14 without significant functional recovery. The patient has been off work and totally disabled since 5/17/14. The request for referral to the ankle specialist was non-certified by Utilization Review on 10/28/14 on the basis that the patient had been approved for 8 physical therapy sessions which should be completed prior to referral. The last available imaging was a plain x-ray dated 7/29/13 which revealed an old fibular fracture and a tiny heel spur, and that no updated imaging had been submitted. MTUS and Official Disability Guidelines are cited. Tramadol, Hydrocodone/APAP, Cyclobenzaprine and Lorazepam were all non-certified on the same date on the basis that MTUS Chronic Pain criteria were not met for their use.

IMR ISSUES, DECISIONS AND RATIONALES

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

Consultation with an ankle specialist (for possible left ankle surgery): Overturned

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 14 Ankle and Foot Complaints Page(s): 381, Chronic Pain Treatment Guidelines Page(s): 10.

Decision rationale: MTUS Chronic Pain Guidelines do not address criteria for referral for ankle and foot problems. The MTUS Chronic Pain citation above states that when a patient is diagnosed with chronic pain and the treatment for the condition is covered in the clinical topics sections but is not addressed in the chronic pain medical treatment guidelines, the clinical topics section applies to that treatment. The ACOEM ankle and foot clinical topics citation states that patients with activity limitation persisting over 4-6 weeks whose activity intolerance is not decreasing with muscle strengthening and who desire surgery to correct an anatomic defect should be referred to a conservative surgeon for specific recommendations and discussion based on expected evidence-based short and long-term outcomes. The clinical documentation in this case supports the referral of this patient to an ankle specialist. She has had ankle pain and difficulty walking at least intermittently since 2009, and continually for the past year. She has not responded to at least 8 previous physical therapy sessions, and is unlikely to do so at this point. Her MRI reveals a possible anatomic defect (ATF ligament tear). Her current primary physician is taking no definitive action in regards to treating her ankle. She should be afforded the opportunity to at least discuss options with an ankle surgeon. Based on the MTUS citations above and on the clinical documentation provided for my review, referral to an ankle specialist is medically necessary, because the patient has long-term ankle pain with gait disturbance and she

has not responded to conservative measures including physical therapy. Her MRI reveals what may be an anatomical defect which could be surgically addressed.

Tramadol 50mg: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Medications for Chronic Pain, Criteria for Use of Opioids, Steps to Take Before a Therapeutic Tr. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: UpToDate, an online evidence-based review service for clinicians (www.uptodate.com), Tramadol: Drug Information

Decision rationale: Tramadol is an opioid analgesic. Per the MTUS recommendations cited above, medications should be trialed one at a time while other treatments are held constant, with careful assessment of function, and there should be functional improvement with each medication in order to continue it. If opioids are used, it is recommended that goals for pain and function be set and monitored. Opioids should be discontinued if there is no improvement in function. There is no good evidence that opioids are effective for radicular pain. If long-term use of opioids occurs, there is a need for ongoing pain and function assessments, as well as assessments for side effects, of concurrent other treatments, and of concurrent psychological issues. Per the UpToDate reference cited above, Tramadol increases the risk of seizures even at recommended doses. This risk is increased in patients on other opioids or Cyclobenzaprine. The clinical findings in this case do not demonstrate that any of the above criteria have been met. There is no documentation that Tramadol was introduced individually, with ongoing careful assessment of function. There is no documentation of evaluation of whether or not the patient's pain is nociceptive or neuropathic. The documented diagnosis of radiculitis makes it appear that the patient's pain is at least in part neuropathic. Neuropathic pain does not necessarily respond well to opioids. No assessment was documented of whether or not opioid use was likely to be helpful in this patient, or of her potential for abuse. No specific functional goals were set or followed. Tramadol is being prescribed with two other medications (Cyclobenzaprine and Hydrocodone) that increase the possibility that Tramadol may cause seizures. The quantity of Tramadol to be dispensed is not documented. Most importantly, Tramadol was not discontinued when it became clear that it has not produced any functional improvement. This patient has remained totally disabled from 5/17/14 to the present, and has been unable to return even to light sedentary work. Based on the evidence-based citations above and on the clinical documentation provided for review, Tramadol 50 mg is not medically necessary. It is not medically necessary because an appropriate evaluation for its use has not been documented, because no functional goals were set or followed for its use, because it is being prescribed with two other medications that increase the possibility that it will cause seizures, because no quantity to be prescribed or dispensed has been specified, and because the patient has demonstrated no functional recovery in response to its use.

Hydrocodone/APAP 10/325mg: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Medications for Chronic Pain, Criteria for Use of Opioids, Steps to Take Before a Therapeutic Tr.

Decision rationale: Hydrocodone is an opioid analgesic. In this case it is combined with APAP, which is Acetaminophen. Per the MTUS recommendations cited above, medications should be trialed one at a time while other treatments are held constant, with careful assessment of function, and there should be functional improvement with each medication in order to continue it. If opioids are used, it is recommended that goals for pain and function be set and monitored. Opioids should be discontinued if there is no improvement in function. There is no good evidence that opioids are effective for radicular pain. If long-term use of opioids occurs, there is a need for ongoing pain and function assessments, as well as assessments for side effects, of concurrent other treatments, and of concurrent psychological issues. The clinical findings in this case do not demonstrate that any of the above criteria have been met. There is no documentation of evaluation of whether or not the patient's pain is nociceptive or neuropathic. The documented diagnosis of radiculitis makes it appear that the patient's pain is at least in part neuropathic. Neuropathic pain does not necessarily respond well to opioids. No assessment was documented of whether or not opioid use was likely to be helpful in this patient, or of her potential for abuse. No specific functional goals were set or followed. The quantity of Hydrocodone/APAP to be dispensed is not documented. Most importantly, Hydrocodone/APAP was not discontinued when it became clear that it has not produced any functional improvement. This patient has remained totally disabled from 5/17/14 to the present, and has been unable to return even to light sedentary work. Based on the evidence-based citations above and on the clinical documentation provided for review, Hydrocodone/APAP 10/325 is not medically necessary. It is not medically necessary because an appropriate evaluation for its use has not been documented, because no functional goals were set or followed for its use, because no quantity to be prescribed or dispensed has been specified, and because the patient has demonstrated no functional recovery in response to its use.

Cyclobenzaprine 10mg: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Medications for Chronic Pain; Muscle relaxants Page(s): 60; 63-66.

Decision rationale: Cyclobenzaprine is a sedating muscle relaxant. Per the first reference cited above, medications should be trialed one at a time while other treatments are held constant, with careful assessment of function, and there should be functional improvement with each medication in order to continue it. Per the second reference, non-sedating muscle relaxants are recommended with caution as a second-line option for short-term treatment of acute exacerbations in patients with chronic low back pain. In most low back pain patients, they show no benefit. There is no additional benefit if they are used in combination with NSAIDs. Efficacy

appears to diminish over time. Cyclobenzaprine is only recommended for a short course of therapy, as there is no evidence to support its long-term use. Its greatest effect appears to occur within the first four days of treatment. Side effects include drowsiness, urinary retention, dry mouth and headaches. Its use should be avoided in patients with arrhythmias, heart block, heart failure and recent myocardial infarction. The clinical documentation in this case does not support the ongoing provision of Cyclobenzaprine to this patient. She has been taking it for at least 11 months, which is definitely long-term use. The quantity of Cyclobenzaprine to be dispensed is not documented. The patient has demonstrated no functional recovery during the time she has been taking Cyclobenzaprine, and remains totally disabled. Based on the MTUS citations above and on the clinical documentation provided for my review, Cyclobenzaprine 10 mg is not medically necessary. It is not medically necessary because it is not indicated for long-term use, because the quantity to be dispensed or prescribed is not specified, and because the patient has demonstrated no functional improvement as a result of its use.

Lorazepam 2mg: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Medications for Chronic Pain; Benzodiazepines Page(s): 60; 24.

Decision rationale: Lorazepam is a benzodiazepine. According to the MTUS references above, medications should be trialed one at a time while other treatments are held constant, with careful assessment of function, and there should be functional improvement with each medication in order to continue it. Benzodiazepines are not recommended for long-term use because long-term efficacy is unproven and there is a risk of dependence. Most guidelines limit us to 4 weeks. Their range of action includes sedative/hypnotic, anxiolytic anticonvulsant and muscle relaxant. Chronic benzodiazepines are the treatment of choice in very few conditions. Tolerance to hypnotic effects develops rapidly. Tolerance to anxiolytic effects occurs within months and long-term use may actually increase anxiety. A more appropriate treatment for anxiety is an antidepressant. Tolerance to anticonvulsant and muscle relaxant effects occurs within weeks. The clinical documentation in this case does not support the continued provision of Lorazepam to this patient. This patient has been taking Lorazepam for at least 11 months, which is long-term use. It is not clear why it is being prescribed, since the patient does not have diagnoses of muscle spasm, anxiety or insomnia. The quantity of Lorazepam to be dispensed is not documented. Whatever it is being prescribed for, the patient has demonstrated no functional recovery in response to taking it, and remains totally disabled. Therefore, this request is not medically necessary.