

Case Number:	CM14-0204301		
Date Assigned:	12/18/2014	Date of Injury:	11/23/2011
Decision Date:	02/03/2015	UR Denial Date:	11/20/2014
Priority:	Standard	Application Received:	12/05/2014

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 New York. 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 is a 44 year old male with a work injury dated 11/23/2011. At presentation on 11/12/2014 the injured worker (IW) continued to have left knee pain. He had a significant limp and was walking with a cane and was unable to do any prolonged standing or walking. Physical exam revealed pain along the left knee medial greater than lateral joint line. There was tenderness along the inner and outer patella with a negative patellar tilt test and a 1 + anterior drawer test. Valgus and varus testing were negative. Lachman test was negative. McMurray's was positive medially and negative laterally. EMG (as documented by provider) in June 2013 was benign and MRI showed disc disease from lumbar 2 through sacral 1. MRI of the left knee 12/13/2013 (as documented by the provider) demonstrated linear signal on the posterior horn of the medial meniscus consistent with tear, joint effusion and bone island in the lateral femoral condyle. Prior exam dated 10/08/2014 revealed right knee extension 170 degrees and flexion 120 degrees. Left knee extension was 170 degrees extension and flexion 110 degrees. Diagnosis included: Internal derangement of the knee on the right one year after meniscectomy; Discogenic lumbar condition with radicular component down the lower extremities and chronic pain syndrome. The provider requested Tramadol ER 150 mg # 30 for pain, Effexor 75 mg # 60 for depression and Protonix 20 mg # 60 for upset stomach. On 11/20/2014 utilization review issued a decision for partial certification for Tramadol ER 150 mg # 15 with no refills and Effexor 75 mg # 30 with no refills. Protonix was non-certified. Rationale given by the reviewer was: The records submitted for review failed to include documentation of the patient's pain level with and without medication, objective functional improvement, the occurrence or non-occurrence of side effects and a decrease in other analgesic medications with the use of Effexor. In addition the records submitted for review failed to include documentation indicating the patient had GI risk to support the use of Protonix. Guidelines cited were: CA MTUS 2009, chronic pain, opioids, criteria for

use, page 78; MTUS 2009, chronic pain, NSAID's, GI symptoms and cardiovascular risk, pages 68-69; MTUS 2009 chronic pain, antidepressants for chronic pain, pages 13-16. The decision was appealed to Independent Medical Review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Tramadol ER 150mg #30: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 93 and 94-96.

Decision rationale: The review of the medical documentation indicates that the requested medication, Tramadol ER 150 mg is not medically necessary and indicated for the treatment of the claimant's chronic pain condition. Per California MTUS, Tramadol is a synthetic opioid which affects the central nervous system and is indicated for the treatment of moderate to severe pain. The treatment of chronic pain with any opioid agent requires review and documentation of pain relief, functional status, appropriate medication use, and side effects. Pain assessment should include current pain: last reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid, and the duration of pain relief. Per the medical documentation there has been no documentation of the medication's pain relief effectiveness and no clear documentation that he has responded to ongoing opioid therapy. According to the California MTUS Guidelines there has to be certain criteria followed including an ongoing review and documentation of pain relief and functional status. This does not appear to have occurred with this patient. In addition, the documentation provided is lacking of California MTUS opioid compliance guidelines including risk assessment profile, attempts at weaning/tapering, updated urine drug screen, updated efficacy, and an updated signed patient contract between the provider and the claimant. The patient may require a multidisciplinary evaluation to determine the best approach to treatment of her chronic pain syndrome. Medical necessity for the requested item is not established. The requested treatment is not medically necessary.

Protonix 20mg #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 68.

Decision rationale: Per California MTUS 2009 proton pump inhibitors are recommended for patients taking NSAIDs with documented GI distress symptoms or specific GI risk factors. There is no documentation indicating the patient has any symptoms or GI risk factors. GI risk factors

include: age >65, history of peptic ulcer, GI bleeding, or perforation; concurrent use of aspirin, corticosteroids, and/or anticoagulants or high dose/multiple NSAID. The claimant has no documented GI issues. Based on the available information provided for review, the medical necessity for Prilosec has not been established. The requested medication is not medically necessary.

Effexor 75mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines antidepressants for chronic pain Page(s): 13-16.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 13-16.

Decision rationale: Venlafaxine (brand names: Effexor, Effexor and Trevilor) is an antidepressant of the serotonin-norepinephrine reuptake inhibitor (SNRI) class. This means it increases the concentrations of the neurotransmitters serotonin and norepinephrine in the body and the brain. First introduced by █████ in 1993, now marketed by █████, it is licensed for the treatment of major depressive disorder (MDD), generalized anxiety disorder (GAD), panic disorder and social phobia. It is usually reserved as a second-line treatment for depression due to a combination of its superior efficacy to the first-line treatments like fluoxetine, paroxetine and citalopram and greater frequency of side effects like nausea, headache, insomnia, drowsiness, dry mouth, constipation, sexual dysfunction, sweating and nervousness. There is no documentation indicating the claimant has a history of depression or that the medication has decreased the use of any other analgesics including opiates. Medical necessity for the requested item has not been established. The requested item is not medically necessary.