

Case Number:	CM14-0216005		
Date Assigned:	02/09/2015	Date of Injury:	01/15/2005
Decision Date:	04/08/2015	UR Denial Date:	11/26/2014
Priority:	Standard	Application Received:	12/23/2014

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
 State(s) of Licensure: Pennsylvania
 Certification(s)/Specialty: Internal Medicine

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 67 year-old female who has reported knee pain after falling on 1/15/05. The diagnoses include internal derangement right knee, osteoarthritis, and chronic pain syndrome. Treatment has included multiple surgeries, physical therapy, injections, brace, transcutaneous electrical nerve stimulation (TENS), and medications. The current treating physician has been seeing this injured worker periodically for at least 5 years. Monthly reports during 2014 reflect worsening pain and that the injured worker was requesting a knee replacement. She was not able to walk more than 3 blocks, and overall function was uniformly poor. She used a cane. Depression due to chronic pain was mentioned, although not explained in any detail. Ongoing medications included Trazodone, Effexor, Norco, Tramadol, Naproxen, and a proton pump inhibitor (PPI) - Protonix. Trazodone was stated to be for depression and insomnia. Effexor was for depression. Insomnia was stated to be caused by pain. Her blood pressure was elevated on multiple occasions. Work status was stated to be "sedentary" at best. All analgesics were reported to provide pain relief. The PPI was prescribed for "upset stomach". No reports addressed and discussed the specific functional improvement that might have resulted from treatment or from any specific medication. As of 11/18/14, there was ongoing and worsening knee pain, and tries to limit her activity. She stays at home nearly all the time. The blood pressure was elevated. The same medications were ongoing, and were refilled. There was no discussion of the specific symptomatic and functional benefit from any medication, or the specific patterns of use. Per a consultant report of 11/19/14, there was ongoing knee pain for which the injured worker was taking Norco only. The only other medication listed which was possibly for pain was tizanidine.

She was able to walk one block only. On 11/26/14 Utilization Review non-certified omeprazole, Effexor, Tramadol, and Trazodone. Norco was partially certified. Note was made of duplicate prescriptions for Trazodone; one was certified and the other was non-certified. The Official Disability Guidelines and the MTUS were cited.

IMR ISSUES, DECISIONS AND RATIONALES

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

One prescription of Norco 10/325mg #90: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioid management; Opioids, steps to avoid misuse/addiction; indications, Chronic back pain; Mechanical and compressive etiologies; Medication trials Page(s): 77-81; 94; 80; 81; 60.

Decision rationale: There is no evidence that the treating physician is prescribing opioids according to the MTUS, which recommends prescribing according to function, with specific functional goals, return to work, random drug testing, opioid contract, and there should be a prior failure of non-opioid therapy. None of these aspects of prescribing are in evidence. Per the MTUS, there is minimal evidence in support of long term opioids for arthritis, and treatment guidelines should be followed (see MTUS citation above). Function in this injured worker is very poor, as walking tolerance is 1-3 blocks and she stays home nearly all the time. This is good evidence that functional improvement has not occurred. There is no evidence of any drug testing. None of the treating physician reports address the specific usage pattern for Norco, any significant improvement in function, or results of any drug testing. The injured worker fails the "return-to-work" criterion for opioids in the MTUS. As currently prescribed, this opioid does not meet the criteria for long term opioids as elaborated in the MTUS and is therefore not medically necessary. This is not meant to imply that some form of oral analgesia is contraindicated; only that the opioids as prescribed have not been prescribed according to the MTUS and that the results of use do not meet the requirements of the MTUS.

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One prescription of Prilosec 20mg #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk Page(s): 68-69.

Decision rationale: There are no medical reports which adequately describe the relevant signs and symptoms of possible gastrointestinal disease. There is no examination of the abdomen. There are many possible etiologies for gastrointestinal symptoms; the available reports do not provide adequate consideration of these possibilities. "Upset stomach" is not a diagnosis and is not an indication for a PPI. Empiric treatment after minimal evaluation is not indicated. Cotherapy with an NSAID is not indicated in patients other than those at high risk. This injured worker is not taking NSAIDs per the latest report. If one were to presume that a medication were to be the cause of the gastrointestinal symptoms, the treating physician would be expected to change the medication regime accordingly, at least on a trial basis to help determine causation. Note the MTUS recommendation regarding the options for NSAID-induced dyspepsia. In this case, there is no evidence of any attempts to determine the cause of symptoms, including minimal attempts to adjust medications. The MTUS, FDA, and recent medical literature have described a significantly increased risk of hip, wrist, and spine fractures; pneumonia, Clostridium-difficile-associated diarrhea, and hypomagnesemia in patients on proton pump inhibitors. Omeprazole is not medically necessary based on lack of medical necessity, lack of sufficient evaluation, and risk of toxicity.

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One prescription of Effexor 75mg #60: 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 Medications for chronic pain; Antidepressants for chronic pain; SSRIs (selective serotonin reuptake inhibitors); SNRIs (serotonin noradrenaline reuptake inhibitors) Page(s): 60; 13-16; 107; 105. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Mental Illness and Stress chapter, treatment of depression.

Decision rationale: Serotonin and norepinephrine reuptake inhibitor (SNRI) antidepressants like Effexor may be prescribed for chronic pain or depression. The treating physician has stated that Effexor is for depression. The MTUS does not provide specific recommendations for using an SNRI to treat depression. The Official Disability Guidelines citation above provides specific recommendations for antidepressants. None of the treating physician reports provide sufficient details regarding any psychiatric condition, the indications for any psychiatric medication, the results of using Effexor, and the reasons why it should be continued. No antidepressant should be continued without good evidence of benefit, symptomatic and functional. There is none of this evidence present in this case. Although there may be an indication for continuing an SNRI antidepressant for the injured worker, the records do not supply the necessary supporting information. It is not even clear that this injured worker takes this medication, given that the secondary physician did not even list it as a current medication. Effexor is not medically necessary based on the MTUS and the Official Disability Guidelines, lack of clear indications, lack of benefit, and lack of evidence that the injured worker actually takes the medication.

One prescription of Tramadol ER 150mg #30: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioid management; Opioids, steps to avoid misuse/addiction; indications, Chronic back pain; Mechanical and compressive etiologies; Medication trials; Tramadol (Ultram) Page(s): 77-81; 94; 80; 81; 60; 94, 113.

Decision rationale: Tramadol is a centrally acting synthetic opioid analgesic which is not recommended as a first line oral analgesic. Multiple side effects have been reported including increased risk of seizure especially in patients taking selective serotonin reuptake inhibitors (SSRIs), tricyclic antidepressants (TCAs) and other opioids. It may also produce life-threatening serotonin syndrome. There is no evidence that the treating physician is prescribing opioids according to the MTUS, which recommends prescribing according to function, with specific functional goals, return to work, random drug testing, opioid contract, and there should be a prior failure of non-opioid therapy. None of these aspects of prescribing are in evidence. Per the MTUS, there is minimal evidence in support of long term opioids for arthritis, and treatment guidelines should be followed (see MTUS citation above). Function in this injured worker is very poor, as walking tolerance is 1-3 blocks and she stays home nearly all the time. This is good evidence that functional improvement has not occurred. There is no evidence of any drug testing. None of the treating physician reports address the specific usage pattern for tramadol, any significant improvement in function, or results of any drug testing. The injured worker fails the "return-to-work" criterion for opioids in the MTUS. It is not even clear that this injured worker takes this medication, given that the secondary physician did not even list it as a current medication. Tramadol has been prescribed simultaneously with an SNRI (Effexor). There are significant risks due to toxicity and this has not been addressed by the treating physician. As currently prescribed, this opioid does not meet the criteria for long term opioids as elaborated in the MTUS and is therefore not medically necessary. This is not meant to imply that some form of oral analgesia is contraindicated; only that the opioids as prescribed have not been prescribed according to the MTUS and that the results of use do not meet the requirements of the MTUS.

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according to the MTUS, which recommends prescribing according to function, with specific functional goals, return to work, random drug testing, opioid contract, and there should be a prior failure of non-opioid therapy. None of these aspects of prescribing are in evidence. Per the MTUS, there is minimal evidence in support of long term opioids for arthritis, and treatment guidelines should be followed (see MTUS citation above). Function in this injured worker is very poor, as walking tolerance is 1-3 blocks and she stays home nearly all the time. This is good evidence that functional improvement has not occurred. There is no evidence of any drug testing. None of the treating physician reports address the specific usage pattern for tramadol, any significant improvement in function, or results of any drug testing. The injured worker fails the "return-to-work" criterion for opioids in the MTUS. It is not even clear that this injured worker takes this medication, given that the secondary physician did not even list it as a current medication. Tramadol has been prescribed simultaneously with an SNRI (Effexor). There are significant risks due to toxicity and this has not been addressed by the treating physician. As currently prescribed, this opioid does not meet the criteria for long term opioids as elaborated in the MTUS and is therefore not medically necessary. This is not meant to imply that some form of oral analgesia is contraindicated; only that the opioids as prescribed have not been prescribed according to the MTUS and that the results of use do not meet the requirements of the MTUS.

One prescription of Trazodone 50mg #60: 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: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain chapter, Insomnia treatment.

Decision rationale: The treating physician has stated that Trazodone is prescribed for depression and insomnia. As per the Effexor discussion above, there is insufficient evidence to support a psychiatric diagnosis, insufficient indications for an antidepressant, and insufficient evidence of benefit from using an antidepressant. With respect to Trazodone as a hypnotic, the MTUS does not address the use of hypnotics other than benzodiazepines. The Official Disability Guidelines were used instead. The Official Disability Guidelines recommend the short term use of hypnotics, discuss the significant side effects, and note the need for a careful evaluation of the sleep difficulties. No physician reports describe the specific criteria for a sleep disorder. The treating physician has not addressed other major issues affecting sleep in this patient, including the use of other psychoactive agents like opioids, which significantly impair sleep architecture. Treatment of a sleep disorder, including prescribing hypnotics, should not be initiated without a careful diagnosis. There is no evidence of that in this case. The reports do not show specific and significant benefit of Trazodone over time. Trazodone is not medically necessary based on prolonged use contrary to guideline recommendations, lack of benefit, and lack of sufficient evaluation of the sleep disorder.