MAXIMUS Federal Services

Case Number:	CM15-0131876		
Date Assigned:	07/20/2015	Date of Injury:	06/24/2009
Decision Date:	09/02/2015	UR Denial Date:	06/09/2015
Priority:	Standard	Application Received:	07/08/2015

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: California
Certification(s)/Specialty: Emergency 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:

The injured worker is a 55 year old male, who sustained an industrial injury on June 24, 2009. He reported bilateral knee pain. The injured worker was diagnosed as having severe right knee strain and left knee torn meniscus and cartilage damage. Treatment to date has included MRI, x-ray, surgery, medication, home exercise program, assistive device for ambulation and injections. Currently, the injured worker complains of severe bilateral knee pain associated with catching and popping. He reports it feels as if the knees want to give out while he is walking. His gait is altered and he uses a cane. He reports low back pain that can radiate down both legs and is becoming worse. The injured worker is diagnosed with left knee osteoarthritis, left knee internal disruption, complete tear of anterior cruciate ligament, right knee pain and lumbar discogenic disease with radicular findings. His work status is temporary total disability. In a note, dated June 3, 2015 it states that on examination there is popping and catching in both knees and a decreased range of motion and reflexes are noted. The note also states the injured worker is experiencing some pain relief from non-steroidal anti-inflammatory medication (efficacy from other treatment modalities was not included in the documentation). The injured worker is scheduled for left total knee replacement. The following medications, Alprazolam 1 mg #30 (date of service May 4, 2015), Tramadol HCL-Acetaminophen 37/5-325 mg #30 (pain relief-date of service May 5, 2015) Omeprazole 20 mg #60 (combat side effects for Naproxen- date of service May 5, 2015) and Naproxen 550 mg #60 (pain relief and anti-inflammatory-date of service May 5, 2015) are requested.

IMR ISSUES, DECISIONS AND RATIONALES

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

Alprazolam 30 x 1mg tab bill DOS 5/4/15: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 24. Decision based on Non-MTUS Citation Official Disability Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 24 of 127.

Decision rationale: The request is for the use of a medication in the category of benzodiazepines. It is usually indicated to treat anxiety disorders but has been used short-term as a muscle relaxant. The MTUS guidelines state the following: Not recommended for long-term use because long-term efficacy is unproven and there is a risk of dependence. Most guidelines limit use to 4 weeks. Their range of action includes 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 disorder is an antidepressant. Tolerance to anticonvulsant and muscle relaxant effects occurs within weeks. (Baillargeon, 2003) (Ashton, 2005) In this case, a medication in this class would not be advised for continued use due to the duration of therapy. As such, the request is not certified.

Tramadol HCL/Acetaminophen 37.5/325mg #60 DOS bill 5/5/15: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 80-83 of 127.

Decision rationale: Tramadol is a pain medication in the category of a centrally acting analgesic. They exhibit opioid activity and a mechanism of action that inhibits the reuptake of serotonin and norepinephrine. Centrally acting drugs are reported to be effective in managing neuropathic type pain although it is not recommended as first line therapy. The side effect profile is similar to opioids. For chronic back pain, it appears to be efficacious for short term pain relief, but long term (>16 weeks) results are limited. It also did not appear to improve function. The use of tramadol for osteoarthritis is indicated for short-term use only (<3 months) with poor long-term benefit. In this case, the patient does not meet the qualifying criteria or indications. As such, the request is not certified.

Omeprazole 20mg #60 DOS bill 5/5/15: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 68 of 127.

Decision rationale: The request is for the use of a medication in the class of a proton pump inhibitor. This is usually given as an acid reducing medication for patients with esophageal reflux, gastritis, or peptic ulcer disease. It can also be used as a preventative measure in patients taking non-steroidal anti-inflammatories for chronic pain. Unfortunately, they do have certain side effects including gastrointestinal disease. The MTUS guidelines states that patients who are classified as intermediate or high risk, should be treated prophylactically. Criteria for risk are as follows: "(1) age > 65 years; (2) history of peptic ulcer, GI bleeding or perforation; (3) concurrent use of ASA, corticosteroids, and/or an anticoagulant; or (4) high dose/multiple NSAID (e.g., NSAID + low-dose ASA)." Due to the fact the patient does not meet to above stated criteria, the request for use is not certified.

Naproxen Sodium 550mg #60 DOS bill 5/5/15: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 67-68 of 127.

Decision rationale: The request is for the use of NSAIDS to aid in pain relief. NSAIDS are usually used to aid in pain and inflammation reduction. The MTUS guidelines states that for osteoarthritis NSAIS are recommended at the lowest dose for the shortest period in patients with moderate to severe pain. Acetaminophen may be considered for initial therapy for patients with mild to moderate pain, for those with gastrointestinal, cardiovascular or renovascular risk factors. NSAIDs appear to be superior to acetaminophen especially for patients with moderate to severe pain. There is no evidence to support one drug in this class over another based on efficacy. In particular, there appears to be no difference between NSAIDs and COX-2 NSAIDs in terms of pain relief. The main concern of selection is based on adverse effects, with COX-2 NSAIDs having fewer GI side effects at the risk of increased cardiovascular side effects. The FDA has concluded that long-term clinical trials are best interpreted to suggest that cardiovascular risk occurs with all NSAIDs and is a class effect (with naproxyn being the safest drug). There is no evidence of long-term effectiveness for pain and function. (Chen, 2008) (Laine, 2008) For back pain, NSAIDS are recommended as a second-line treatment after acetaminophen. In general, there is conflicting evidence that NSAIDs are more effective that acetaminophen for acute LBP. (van Tulder, 2006) (Hancock, 2007) For patients with acute low back pain with sciatica a recent Cochrane review (including three heterogeneous randomized controlled trials) found no differences in treatment with NSAIDs vs. placebo. In patients with axial low back pain, this same review found that NSAIDs were not more effective than acetaminophen for acute low-back pain, and that acetaminophen had fewer side effects. (Roelofs-Cochrane, 2008) The addition of NSAIDs or spinal manipulative therapy does not appear to increase recovery in patients with acute low back pain over that received with acetaminophen treatment and advice from their physician. (Hancock, 2007) In this case, there is inadequate documentation of functional improvement to justify continued use, as the guidelines recommend the lowest dose for the shortest period of time. The significant side effect profile of medications in this class put the patient at risk when used chronically. As such, the request is not certified.