MAXIMUS Federal Services

Case Number:	CM15-0137331		
Date Assigned:	07/27/2015	Date of Injury:	07/15/2002
Decision Date:	09/28/2015	UR Denial Date:	06/19/2015
Priority:	Standard	Application Received:	07/15/2015

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: Colorado
Certification(s)/Specialty: Family Practice

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 74-year-old female, with a reported date of injury of 07/15/2002. The mechanism of injury was not indicated in the medical records provided for review. The injured worker's symptoms at the time of the injury were not indicated. The diagnoses include left knee internal derangement, discogenic lumbar condition, status post left knee meniscectomy, ankle inflammation, and chronic pain syndrome. Treatments and evaluation to date have included oral medications and topical pain medications. The diagnostic studies to date have included an MRI of the right knee on 05/07/2015 which showed two distinct lesions in the distal femur, small subchondral cystic lesions in the tibial plateau, and small joint effusion. According to the medical report dated 08/15/2014, diagnostic studies have included an MRI of the lumbar spine in 2006 showed lumbar disc disease; nerve studies in 2012 showed some marginal peroneal involvement; an MRI of the right knee showed degenerative changes; and an MRI of the ankle showed some arthritic changes along the tibiotalar joint and some cystic changes with effusion. The medical report dated 06/09/2015 indicates that the injured worker had low back pain, left knee pain, and left ankle pain. It was noted that she took medications to be functional. The injured worker took Remeron for sleep and Norco for pain. The objective findings include tenderness across the thoracic and lumbar paraspinal muscles, pain with facet loading, left knee extension at 165 degrees, left knee flexion at 125 degrees, tenderness across the left knee joint line with positive McMurray's medial and negative laterally, positive compression test, and positive inhibition test on the left. The injured worker is retired. The injured worker reported getting 40% reduction in pain, which helped her better able to sleep with Norco; and Remeron

helped her sleep through the night. It was noted that she was still waking up most of the time at night due to pain. The treating physician requested Norco, Remeron, and x-rays of the left knee.

IMR ISSUES, DECISIONS AND RATIONALES

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

Norco 10/325mg, #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, specific drugs list-Hydrocodone/Acetaminophen; Criteria for use of Opioids, Weaning of Medications.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Pain Interventions and Treatments Page(s): 79-80, 85, and 88-89.

Decision rationale: The Guidelines establish criteria for use of opioids, including long term use (6 months or more). When managing patients using long term opioids, the following should be addressed: Re-assess the diagnosis and review previous treatments and whether or not they were helpful. When re-assessing, pain levels and improvement in function should be documented. Pain levels should be documented every visit. Function should be evaluated every 6 months using a validated clinical assessment tool. Adverse effects, including hyperalgesia, should also be addressed each visit. Patient's motivation and attitudes about pain/work/interpersonal relationships can be examined to determine if patient requires psychological evaluation as well. Aberrant/addictive behavior should be addressed if present. Do not decrease dose if effective. Medication for breakthrough pain may be helpful in limiting overall medication. Follow up evaluations are recommended every 1-6 months. To summarize the above, the 4A's of Drug Monitoring (analgesia, activities of daily living, adverse side effects, and aberrant drug-taking Behaviors) have been established. The monitoring of these outcomes over time should affect therapeutic decisions and provide a framework for documentation of the clinical use of these controlled drugs. (Passik, 2000) Several circumstances need to be considered when determining to discontinue opioids: 1) Verify patient has not had failure to improve because of inappropriate dosing or under-dosing of opioids. 2) Consider possible reasons for immediate discontinuation including diversion, prescription forgery, illicit drug use, suicide attempt, arrest related to opioids, and aggressive or threatening behavior in clinic. Weaning from the medication over 30 day period, under direct medical supervision, is recommended unless a reason for immediate discontinuation exists. If a medication contract is in place, some physicians will allow one infraction without immediate discontinuation, but the contract and clinic policy should be reviewed with patient and consequences of further violations made clear to patient. 3) Consider discontinuation if there has been no improvement in overall function, or a decrease in function. 4) Patient has evidence of unacceptable side effects. 5) Patient's pain has resolved. 6) Patient exhibits "serious non-adherence" or misuse. Per the Guidelines, Chelminski defines "serious substance misuse" as meeting any of the following criteria: (a) cocaine or amphetamines on urine toxicology screen (positive cannabinoid was not considered serious substance abuse); (b) procurement of opioids from more than one provider on a regular basis; (c) diversion of opioids; (d) urine toxicology screen negative for prescribed drugs on at least two occasions (an indicator of possible diversion); & (e) urine toxicology screen positive on at least two occasions for

opioids not routinely prescribed. (Chelminski, 2005) 7) Patient requests discontinuing opioids. 8) Consider verifying that patient is in consultation with physician specializing in addiction to consider detoxification if patient continues to violate the medication contract or shows other signs of abuse/addiction. 9) Document the basis for decision to discontinue opioids. Likewise, when making the decision to continue opioids long term, consider the following: Has patient returned to work. “Has patient had improved function and decreased pain with the opioids" Per the records for the patient of concern, she has had no documented improvement in function with her current regimen which includes Norco. The recent statements in the record about pain improvement indicate 30-40% improvement in pain, but there are no documented pain ratings to support that. There are no documented discussions of the risks of long term opioid use, or discussion of the possible side effects/aberrant drug taking behavior. There is no evidence that patient has had monitoring for abuse of opioids. Without evidence that the patient has improved with regard to function on opioids, and without evidence that appropriate monitoring of opioid use is ongoing, the Norco refill request is not medically necessary.

Remeron 15mg, #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), Pain (Chronic): Insomnia treatment.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Pain Interventions and Treatments Page(s): 14-16. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Mental Illness and Stress, Insomnia Treatment.

Decision rationale: Per the MTUS Guidelines, antidepressants can be considered first line treatment for neuropathic pain and possible option for treatment for non-neuropathic pain. Tricyclic antidepressants are the recommended first option for treatment of pain with antidepressant and should be used unless ineffective or not tolerated/contraindicated. Pain relief with antidepressants may occur within a few days to 1 week, though any antidepressant effect would take longer to occur. As with other treatments for pain, efficacy should be assessed regularly when using antidepressants. The following aspects associated with pain relief should be addressed: Pain reduction, Improvement in function, Changes in need for other pain medications, Sleep quality and quantity, Psychiatric evaluation, Side effects, especially those that may affect job performance. Long-term efficacy of anti-depressants in treatment of pain is not known, and antidepressants in combination with other medications for pain have no quality evidence to support use. The MTUS Guidelines do not address Remeron specifically, so the ODG was consulted. Per the ODG, sedating antidepressants such as Remeron can be used for sleep, but tend to be more effective at treatment of depression, less so for the insomnia. For the patient of concern, the records do not indicate any depressive symptoms, just sleep issues. The record does not indicate if the sleep issues involve sleep initiation or quality, and the record does indicate that pain is what wakes patient night, even when taking Remeron. The records do not include any recent discussion of sleep hygiene or other options tried to help with sleep. Without more information of the nature of patient's sleep issue and previous attempts to correct it, and with at least the suggestion that patient's pain is the cause of her sleep issues specifically the Remeron is not medically necessary.

Retrospective X-rays of the left knee, completed on 06/09/2015: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 331, 343.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 341 and 343.

Decision rationale: The MTUS Guidelines do not address the use of x-rays for knee pain, so the ACOEM was consulted. Per the ACOEM, diagnostic studies are not generally to be considered unless patient has red flag symptoms or findings or has failed conservative therapy. The American College of Radiology (ACR) provides guidance with its appropriateness criteria (clinical parameters that can predict absence of significant fracture) for imaging after knee trauma: Patient is able to walk without a limp, Patient had a twisting injury and there is no effusion. The clinical parameters for ordering knee radiographs following trauma in this population are: Joint effusion within 24 hours of direct blow or fall, Palpable tenderness over fibular head or patella, Inability to walk (four steps) or bear weight immediately or within a week of the trauma, Inability to flex knee to 90 degrees. Hemarthrosis and a history of acute trauma, may be indications for radiography to evaluate for fracture. However, imaging studies should not be the only tool used to evaluate knee symptoms as false positive results can adversely affect management. MRI however can be useful if ACL tear is suspected given the common missed and over diagnosed cases of ACL tear. For the patient of concern, the notes do not indicate recent trauma to the left knees; this is a chronic issue. There are no red flag findings, ROM > 90 flex and extend. Without evidence that patient has acute trauma that would put her at risk for fracture, and /or evidence of failure of conservative treatment following recent trauma, x-rays of the left knee would not be medically necessary.