

Case Number:	CM15-0140617		
Date Assigned:	08/05/2015	Date of Injury:	07/29/2013
Decision Date:	09/25/2015	UR Denial Date:	06/18/2015
Priority:	Standard	Application Received:	07/20/2015

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: Arizona, Michigan

Certification(s)/Specialty: Preventive Medicine, Occupational 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 female, who sustained an industrial injury on 07-29-2013. She has reported subsequent back, knee, ankle and lower extremity pain and was diagnosed with musculoligamentous sprain of the lumbar spine with right extremity radiculitis, sprain of the cervical spine with upper extremity radiculitis, tear of the glenoid labrum of the right shoulder and partial rotator cuff tear status post arthroscopy of the right shoulder with resection and debridement, lateral epicondylitis of the right elbow, carpal tunnel syndrome, lateral ligament injury of the left ankle, peroneal tendon injury on the left, internal derangement of the left knee with possible meniscal tear, avulsion fracture of the lateral malleolus of the left ankle, tear of the medial meniscus of the left knee, osteoarthritis of the left knee and cervical, thoracic and lumbar disc bulges. Treatment to date has included medication, Ketorolac injection, a home exercise program and surgery. Documentation shows that Tramadol, Cyclobenzaprine and Lorazepam had been prescribed since at least 01-05-2015. In a progress note dated 06-15-2015, objective findings were notable for moderate effusion of the left ankle. The injured worker was scheduled to undergo arthroscopy of the left ankle and would be non-weight bearing on the left ankle for 6 weeks following the procedure. The injured worker was noted to be off work. A request for authorization of steerable knee walker, Tramadol 50 mg, Cyclobenzaprine 10 mg and Lorazepam 2 mg was submitted.

IMR ISSUES, DECISIONS AND RATIONALES

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

Steerable knee walker: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Ankle & Foot (Acute & Chronic) Chapter, Rolling Knee Walker.

Decision rationale: CA MTUS does not address the need for steerable knee walker so alternative guidelines were referenced. As per ODG, a rolling knee walker is recommended for patients who cannot use crutches, standard walkers or other standard ambulatory assistive devices (such as a patient with an injured foot who only has the use of one arm). Documentation shows that the injured worker was scheduled to undergo a left ankle arthroscopy and would be non-weight bearing on the left ankle for 6 weeks following the procedure. Although a steerable knee walker would be reasonable for the 6 weeks after surgery, there is no duration of time noted on the request. The documentation does not support the need for the walker beyond the 6 week time frame after surgery. Therefore, the request for authorization of steerable knee walker is not medically necessary.

Tramadol 50mg: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74-96.

Decision rationale: The medication requested for this patient is Tramadol. According to the CA MTUS guidelines, Tramadol is a synthetic opioid which affects the central nervous system and is indicated for the treatment of moderate to severe pain. This medication is not recommended as a first-line oral analgesic. The treatment of chronic pain with any opioid analgesic requires review and documentation of pain relief, functional status, appropriate medication use, and side effects. A pain assessment should include current pain, intensity of pain after taking the opiate, and the duration of pain relief. The documentation shows that this medication had been prescribed to the injured worker since at least 01-05-2015 and there was no documentation of any significant functional improvement or pain reduction with the use of opioid medication. There was no documentation of the severity of pain, average pain, the intensity of pain after taking the opiate or the duration of pain relief. There was no documentation of a change in work status and pain was noted to have worsened despite use of the medication. MTUS indicates that opioids should be discontinued with no overall improvement in function unless there is documentation of extenuating circumstances. Medical necessity of the requested item has not been established. Of note, discontinuation of an opioid analgesic should include a taper, to avoid withdrawal symptoms. Therefore, the request for authorization of Tramadol is not medically necessary.

Cyclobenzaprine 10mg: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants Page(s): 63-66.

Decision rationale: According to CA MTUS guidelines, Cyclobenzaprine (Flexeril) is not recommended for the long-term treatment of chronic pain. Guidelines state that this medication is not recommended to be used for longer than 2-3 weeks. According to CA MTUS Guidelines, muscle relaxants are not considered any more effective than non-steroidal anti-inflammatory medications alone. Documentation shows that Cyclobenzaprine had been prescribed to the injured worker since at least 01-05-2015. There is no documentation of objective functional improvement from the use of this medication as there is no documentation of a change in work status or improved quality of life. There is no documentation of a significant reduction in pain and the most recent progress notes show that pain had worsened. In addition, this medication is not recommended for long term use. Based on the currently available information, the medical necessity for this muscle relaxant medication has not been established. The request for Cyclobenzaprine is not medically necessary. There is also no documented frequency, quantity or instructions for use specified. Therefore, the request for Cyclobenzaprine is not medically necessary.

Lorazepam 2mg: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines Page(s): 24. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain (Chronic) Chapter, Benzodiazepines.

Decision rationale: Lorazepam is a long-acting benzodiazepine, having anxiolytic, sedative, muscle relaxant, anticonvulsant, and hypnotic properties. Most guidelines recommend the use of Lorazepam for the treatment of anxiety disorders, and as an adjunct treatment for anxiety associated with major depression. Use of this medication is limited to four weeks. Documentation shows that this medication was prescribed to the injured worker since at least 01-05-2015. There is no documentation provided indicating that the patient is maintained on any antidepressant medication and there is no documentation of a psychiatric diagnosis. In addition, there are no guideline criteria that support the long-term use of benzodiazepines. There is also no documented frequency, quantity or instructions for use specified. Medical necessity for the requested medication has not been established. The requested medication is not medically necessary.