

Case Number:	CM15-0052659		
Date Assigned:	03/26/2015	Date of Injury:	09/20/2006
Decision Date:	05/14/2015	UR Denial Date:	02/20/2015
Priority:	Standard	Application Received:	03/19/2015

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: Physical Medicine & Rehabilitation

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 reported injury on 09/20/2006. The mechanism of injury was not provided. The diagnoses included pain in the limb, lumbar disc displacement without myelopathy, lumbar disc disorder without myelopathy, current tear of the cartilage or meniscus of the knee, and derangement of the lateral meniscus. The documentation of 01/22/2015 revealed the injured worker had complaints of low back pain and left sided knee pain. The injured worker had spasms, tenderness, and guarding in the paravertebral muscles of the lumbar spine with decreased range of motion. The injured worker had loss of motor strength over the left knee graded a 4/5. The injured worker had a well healed incision over the operative site of the left knee. The injured worker was advised to continue home exercises. The injured worker's medications were noted to be refilled and were noted to reduce pain and increase functional activity. There was no Request for Authorization submitted for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Anaprox 550 mg, ninety count: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS Page(s): 67.

Decision rationale: The California Medical Treatment Utilization Schedule Guidelines recommend NSAIDs for the short term symptomatic relief of mild to moderate pain. There should be documentation of objective functional improvement and an objective decrease in pain. The clinical documentation submitted for review failed to provide documentation of an objective decrease in pain and objective functional improvement. The request as submitted failed to indicate the frequency for the requested medication. Given the above, the request for Anaprox 550 mg, 90 count is not medically necessary.

Prilosec 20 mg, ninety count: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS Page(s): 69.

Decision rationale: The California Medical Treatment Utilization Schedule Guidelines recommend proton pump inhibitors for injured workers at intermediate or higher risk for gastrointestinal events. They are recommended for the treatment of dyspepsia secondary to NSAID therapy. The clinical documentation submitted for review failed to provide a rationale for the request. There was a lack of documentation indicating the injured worker was at intermediate or higher risk for gastrointestinal events. There was a lack of documentation of signs and symptoms of dyspepsia. The efficacy for the requested medication was not provided. The request as submitted failed to indicate the frequency for the requested medication. Given the above, the request for Prilosec 20 mg, 90 count is not medically necessary.

Tramadol ER 150 mg, sixty count: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Medications for Chronic pain, ongoing management Page(s): 60, 78.

Decision rationale: The California Medical Treatment Utilization Schedule Guidelines recommend opiates for the treatment of chronic pain. There should be documentation of objective functional improvement, an objective decrease in pain, and documentation the injured worker is being monitored for aberrant drug behavior and side effects. The clinical documentation submitted for review failed to provide documentation of objective functional improvement, an objective decrease in pain, and documentation the injured worker was being monitored for aberrant drug behavior and side effects. The request as submitted failed to

indicate the frequency for the requested medication. Given the above, the request for tramadol ER 150 mg, 60 count is not medically necessary.

Lidocaine patches, ten count: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Lidoderm Page(s): 56, 57.

Decision rationale: The California Medical Treatment Utilization Schedule Guidelines indicate that topical lidocaine (Lidoderm) may be recommended for localized peripheral pain after there has been evidence of a trial of first line therapy (tricyclic or SNRI antidepressants or an AED such as gabapentin or Lyrica). This is not a first line treatment and is only FDA approved for postherpetic neuralgia. Further research is needed to recommend this treatment for chronic neuropathic pain disorders other than postherpetic neuralgia. No other commercially approved topical formulations of lidocaine (whether creams, lotions or gels) are indicated for neuropathic pain. The clinical documentation submitted for review failed to provide documentation of a trial and failure of first line therapy. There was a lack of documentation indicating whether the lidocaine patches were the generic for Lidoderm patches. The request as submitted failed to indicate the frequency and specific strength. There was a lack of documentation of the body part to be treated and the efficacy for the requested medication. Given the above, the request for lidocaine patches, 10 count is not medically necessary.

Glucosamine/Chondroitin 500/400 mg, 100 count: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Glucosamine (and Chondroitin Sulfate) Page(s): 50.

Decision rationale: The California Medical Treatment Utilization Schedule Guidelines recommend glucosamine and chondroitin for injured workers with moderate arthritis pain, including knee osteoarthritis. The clinical documentation submitted for review failed to provide documentation the injured worker had knee osteoarthritis. The request as submitted failed to indicate the frequency for the requested medication. Given the above, the request for glucosamine/chondroitin 500/400 mg, 100 count is not medically necessary.

Tylenol #3, thirty count: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Medications for Chronic pain, ongoing management, opioid dosing Page(s): 60, 78, 86.

Decision rationale: The California Medical Treatment Utilization Schedule Guidelines recommend opiates for the treatment of chronic pain. There should be documentation of objective functional improvement, an objective decrease in pain, and documentation the injured worker is being monitored for aberrant drug behavior and side effects. The clinical documentation submitted for review failed to provide documentation of objective functional improvement, an objective decrease in pain, and documentation the injured worker was being monitored for aberrant drug behavior and side effects. The request as submitted failed to indicate the frequency for the requested medication. The request as submitted failed to indicate the specific mg that were requested. This was not a determining factor for denial. Given the above, the request for Tylenol No. 3, thirty count is not medically necessary.