

<b>Case Number:</b>	CM15-0056863		
<b>Date Assigned:</b>	04/16/2015	<b>Date of Injury:</b>	09/03/2003
<b>Decision Date:</b>	06/09/2015	<b>UR Denial Date:</b>	03/23/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/25/2015

### 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, Washington

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Pain Management

### 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 72 year old female, who sustained an industrial injury on September 3, 2003. The injured worker was diagnosed as having unspecified internal derangement of knee, status post bilateral total knee replacement, radial styloid tenosynovitis, de Quervains disease, and chronic pain syndrome. Treatment to date has included knee bracing, a two lead TENS unit, a hot/cold wrap, and medications. On March 11, 2015, the injured worker reported left greater than right knee problems, increased difficulty rising from a chair, shooting left calf pain, lack of energy, and a sudden inability to squat and kneel due to knee pain. She has been unable to return to work since 2004. The physical exam revealed tenderness along the bilateral knees, more so on the left. There was decreased bilateral knee range of motion and mild instability with weakness of resisted function. The treatment plan included a Four Lead TENS unit and conductive garment, a hot and cold wrap, and medications.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**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  
Page(s): 74-82.

**Decision rationale:** California MTUS Guidelines state a therapeutic trial of opioids should not be employed until the patient has failed to respond to non-opioid analgesics. Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects should occur. The injured worker has continuously utilized the above medication. It was noted on 06/25/2014, the injured worker's prescription for tramadol ER was discontinued as it made her extremely ill. The medical necessity for the use of the above medication has not been established in this case. There is also no frequency listed in the request. Given the above, the request is not medically necessary.

**Lunesta 2mg #30:** 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 Chapter, Insomnia treatment.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chronic Pain Chapter, Insomnia Treatment.

**Decision rationale:** The Official Disability Guidelines recommend insomnia treatment based on etiology. Lunesta has demonstrated reduced sleep latency and sleep maintenance. In this case, the injured worker has continuously utilized the above medication for an unknown duration. Despite the ongoing use of this medication, the injured worker continues to report issues with sleep, stress and depression. The medical necessity for the ongoing use of this medication has not been established. Guidelines do not support long term use of hypnotics. There is also no frequency listed in the request. Given the above, the request is not medically necessary.

**Venlafaxine 75mg #60:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressants for chronic pain.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines  
Page(s): 123.

**Decision rationale:** California MTUS Guidelines recommend venlafaxine as an option in first line treatment of neuropathic pain. In this case, the injured worker has continuously utilized the above medication for an unknown duration. Despite the ongoing use of this medication, the injured worker continues to report issues with sleep, stress and depression. The injured worker also reports ongoing pain in the bilateral lower extremities. The medical necessity for the ongoing use of this medication has not been established. There is also no frequency listed in the request. Given the above, the request is not medically necessary.

**Lidoderm patches 5% #30: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines  
Page(s): 111-113.

**Decision rationale:** California MTUS Guidelines state lidocaine is indicated for neuropathic pain or localized peripheral pain after there has been evidence of a trial of first line therapy with an antidepressant or an anticonvulsant. There is no documentation of a failure to respond to first line oral medication prior to the initiation of topical lidocaine. In addition, there is no frequency listed in the request. Given the above, the request is not medically necessary.

**Fenoprofen calcium 400mg #60: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines  
Page(s): 67-72.

**Decision rationale:** California MTUS Guidelines state NSAIDS are recommended for osteoarthritis at the lowest dose for the shortest period in patients with moderate to severe pain. For acute exacerbations of chronic pain, NSAIDS are recommended as a second line option after acetaminophen. In this case, the injured worker has continuously utilized the above medication for an unknown duration. There is no documentation of an acute exacerbation of chronic pain with unresponsiveness to first line treatment with acetaminophen. In addition, there is no frequency listed in the request. As such, the request is not medically necessary.

**Pantopraole Sodium 20mg #60: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines  
Page(s): 68-69.

**Decision rationale:** California MTUS Guidelines state, proton pump inhibitors are recommended for patients at intermediate or high risk for gastrointestinal events. Patients with no risk factor and no cardiovascular disease do not require the use of a proton pump inhibitor, even in addition to a nonselective NSAID. In this case, there was no documentation of cardiovascular disease or increased risk factors for gastrointestinal events. The medical necessity for the requested medication has not been established. Additionally, there is no frequency listed in the request. As such, the request is not medically appropriate.

**Cyclobenzaprine 7.5mg #60:** Upheld

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

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

**Decision rationale:** California MTUS Guidelines state muscle relaxants are recommended as non-sedating second line options for short term treatment of acute exacerbations. Cyclobenzaprine is not recommended for longer than 2 to 3 weeks. There is no documentation of a palpable muscle spasm or spasticity upon examination. The medical necessity for a muscle relaxant has not been established. There is also no frequency listed in the request. As such, the request is not medically necessary.

**IF or muscle stimulator four lead TENS unit with conductive garment:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrotherapy, Interferential current stimulation.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 114-117.

**Decision rationale:** California MTUS Guidelines do not recommend transcutaneous electrotherapy as a primary treatment modality, but a 1 month home based trial may be considered as a noninvasive conservative option. A 2 lead unit is generally recommended; if a 4 lead unit is recommended, there must be documentation of why this is necessary. A form fitting TENS device is only considered medically necessary when there is documentation of a large area that requires stimulation that a conventional system cannot accommodate. In this case, the injured worker has continuously utilized a TENS unit. There is no documentation of how often the unit is used as well as any outcomes in terms of pain relief or function. The medical necessity for a 4 lead unit has not been established. Given the above, the request is not medically necessary.

**Hot & Cold wrap:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 337.

**Decision rationale:** California MTUS/ACOEM Practice Guidelines state patients at home local applications of heat or cold packs may be used before or after exercise and are as effective as those performed by a therapist. There is no mention of a contraindication to at home local

applications of heat or cold packs as opposed to a motorized mechanical device. The medical necessity has not been established in this case. Therefore, the request is not medically appropriate.