

<b>Case Number:</b>	CM14-0095365		
<b>Date Assigned:</b>	07/25/2014	<b>Date of Injury:</b>	10/07/2011
<b>Decision Date:</b>	10/03/2014	<b>UR Denial Date:</b>	06/12/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/23/2014

### 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. The expert reviewer is Board Certified in Internal Medicine and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### 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 an injury on 10/07/2011. Mechanism of injury was not provided. The injured worker had diagnoses of lumbar sprain/strain, left lumbar radiculopathy, lumbar degenerative disc disease, left knee sprain, multilevel disc degeneration, lumbar spine mild multifactorial acquired central canal spinal stenosis. The past medical treatment included medications, electrical therapy, cryotherapy, mechanical traction, and chiropractic therapy. Diagnostic studies included x-rays of the lumbar spine which were performed on 3/14/14, x-rays of the pelvis which were performed on 3/14/2014, an MRI of the left knee which was performed on 02/27/2012, and an MR arthrogram which was performed on 07/31/2013. The injured worker underwent left total knee arthroplasty 01/02/2014. The injured worker complained of pain to the entire lower back rated 9/10. The physical examination revealed lumbar flexion and extension were decreased with pain, and pain was noted upon left and right lateral flexion. Medications included Oxycodone, Naproxen, and gabapentin. The treatment plan was for Naprosyn 550mg #60, Gralise 300mg #60, and Oxycodone 15mg #135. The rationale for the request was not submitted. The request for authorization form was not submitted.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Naprosyn 550mg, #60.:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Naproxen (Naprosyn); NSAIDs (non-steroidal anti-inflammatory drugs).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAID's (non-steroidal anti-inflammatory drugs) Page(s): 67-72.

**Decision rationale:** The request for Naprosyn 550mg, #60, is not medically necessary. The injured worker has a diagnoses of lumbar sprain/strain, left lumbar radiculopathy, lumbar degenerative disc disease, left knee sprain, multilevel disc degeneration, lumbar spine mild multifactorial acquired central canal spinal stenosis. The California MTUS guidelines recommend the use of NSAIDs for patients with osteoarthritis (including knee and hip) and patients with acute exacerbations of chronic low back pain. The guidelines recommend NSAIDs 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, and in particular, for those with gastrointestinal, cardiovascular or renovascular risk factors. In patients with acute exacerbations of chronic low back pain, the guidelines recommend NSAIDs as an option for short-term symptomatic relief. There is a lack of documentation indicating the injured worker has been diagnosed with osteoarthritis. There is a lack of documentation of a measured assessment of the injured worker's pain level. The injured worker has been prescribed the medication since at least 05/2014. The continued use of the medication would exceed the guideline recommendation for a short course of treatment. The requesting physician's rationale for the request is not indicated within the provided documentation. Additionally, the request does not indicate the frequency at which the medication is prescribed in order to determine the necessity of the medication. Therefore the request for Naprosyn 550mg, #60, is not medically necessary.

**Gralise 300mg, #60.:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Anti-epilepsy drugs (AEDs) for pain. Page(s): 18-19.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Antiepilepsy drugs, and Gabapentin (Neurontin) Page(s): 16-18; 49.

**Decision rationale:** The request for Gralise 300mg, #60 is not medically necessary. The injured worker complained of pain to entire lower back rating it at a 9/10 on the pain scale. The California MTUS guidelines state anti-epilepsy drugs such as Gralise are recommended for neuropathic pain. A "good" response to the use of AEDs (anti epilepsy drugs) has been defined as a 50% reduction in pain and a "moderate" response as a 30% reduction, after initiation of treatment there should be documentation of pain relief and improvement in function as well as documentation of side effects incurred with use. The continued use of AEDs depends on improved outcomes versus tolerability of adverse effects. There is a lack of documentation indicating the injured worker has significant objective functional improvement with the medication. There is a lack of documentation demonstrating significant reduction of pain with Gralise. Additionally, the request does not indicate the frequency at which the medication is

prescribed in order to determine the necessity of the medication. Therefore, the request for Gralise 300mg, #60 is not medically necessary.

**Oxycodone 15mg, #135.:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Oxycodone/acetaminophen (Percocet; generic available); Opioids, cr.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use Page(s): 78.

**Decision rationale:** The request for Oxycodone 15mg, #135 is not medically necessary. The injured worker complained of pain to entire lower back rating it at a 9/10 on the pain scale. The California MTUS guidelines recommend ongoing review with documentation of pain relief, functional status, appropriate medication use, and side effects. Pain assessment should include current pain, the least reported pain over the period since last assessment, average pain, intensity of pain after taking the opioid, how long it takes for pain relief, and how long pain relief lasts. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. The guidelines also recommend providers assess for side effects and the occurrence of any potentially aberrant (or nonadherent) drug-related behaviors. There is a lack of documentation the patient has improved functioning and pain with the use of the medication. There is a lack of documentation of a measured assessment of the injured worker's pain level. Additionally, the request does not indicate the frequency at which the medication is prescribed in order to determine the necessity of the medication. Therefore, the request for Oxycodone 15mg, #135 is not medically necessary.