

<b>Case Number:</b>	CM14-0004014		
<b>Date Assigned:</b>	01/31/2014	<b>Date of Injury:</b>	08/01/1993
<b>Decision Date:</b>	01/30/2015	<b>UR Denial Date:</b>	12/10/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/09/2014

### 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 Anesthesiology, has a subspecialty in Pain Medicine and is licensed to practice in Georgia. 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 patient is a 54 year old male presenting with a work related injury on 08/01/1993 and 08/31/2001. On 12/12/2013, the patient complained of neck pain. The patient underwent the first of two diagnostic cervical epidural steroid injections at C6 - C7 on December 2, 2013. The patient reported at least 50% pain relief to his neck as well as radicular symptoms to both upper extremities, which resulted in improved mobility connectivity tolerance. The patient reported that his pain was slowly returning and rated the neck pain and 8/10 intensity. According to the medical records since his lumbar epidural steroid injection on October 7, 2013 which provided 50% reduction in his low back pain, the patient has been cut back on the amount of Norco he takes from 10 tablet a day to 68 tablets a day. Electrodiagnostic studies of the bilateral lower extremities on September 10, 2013 was significant for moderate to severe L5 radiculopathy. On that day the patient also complained of ongoing pain in both knees, with the right being greater than the left. The patient did receive a series of injections bending on July 5, 2013 which was reported as beneficial. The physical exam on that day was significant for morbid obesity, stiff, antalgic gait favoring the left lower extremity, the patient uses a single point cane in his right hand, cervical spine tenderness to palpation along the posterior cervical musculature bilaterally with decreased range of motion, significant muscle rigidity along the cervical musculature, upper trapezius and medial scapular region. Examination of the bilateral upper extremities revealed decreased sensation with Wartenberg pinwheel along the lateral arm and forearm bilaterally, Tinel along the ulnar group bilaterally as well as along the left wrist, diffuse muscle atrophy along the dinar and-PR muscles bilaterally, profound loss of sensation in the ulnar nerve distribution with the wrist proximal and distal. Examination of the lumbar spine revealed tenderness to palpation along the lumbar musculature bilaterally with increased muscle rigidity, decreased range of motion but able to for flex bringing his fingertips to render level of the knee,

and extension is limited to 10, pain with both maneuvers, but worse with flexion, decreased sensation along the L5 distribution bilaterally, straight leg raise performed in the modified sitting position is positive on the left at 60 and on the right at about 45. Examination of the patient right knee revealed tenderness to palpation along the medial and lateral joint line with mild crepitus noted with general range of motion there was a positive McMurray's sign in the right knee in comparison to the left knee. Examination of the left ankle shows there is obvious swelling to the left ankle as well there is a clean, well-healed surgical scar on the lateral side of the ankle there's tenderness to palpation throughout. The range of motion and decreased in all planes as well. The patient is slightly hypersensitive throughout his foot, there's a reddish color to the ankle. EMG study of the bilateral upper extremities performed on September 10, 2013 revealed bilateral carpal tunnel syndrome, bilateral ulnar nerve compartment syndrome at the elbow with the left being greater than the right. MRI of the right knee was significant for tear of the posterior inferior margin of the medial meniscus and a grade 2 signal in the lateral meniscus; there is a large popliteal fluid collection in the posterior medial knee. Cervical MRI on August 3, 2010 was significant for C3 - C4 2 mm central disc protrusion with hypertrophic facet changes, C4 - C5 1 to 2 mm posterior disc protrusion with hypertrophic facet changes 3 mm posterior disc protrusion with hypertrophic facet changes, C5 to C6 there's a 3 mm posterior disc protrusion, and at C6 - C7 there is a 2 mm disc protrusion with hypertrophic facet changes. MRI of the lumbar spine on March 18, 2000 and revealed T12 - L12 millimeters disc protrusion; disc the president, L2 - L3 is a 2 mm central disc protrusion; hypertrophic facet changes at present; L3 - L4 has a 2 mm posterior disc protrusion present, spondylosis is present, moderate hypertrophic facet changes at present. The patient was diagnosed with cervical degenerative disc disease with facet arthropathy and bilateral upper extremity radiculopathy thoracic spine sprain/strain syndrome with spondylolisthesis at T9 - T10. Lumbar degenerative disc disease with facet arthropathy and foraminal narrowing and associated bilateral lower extremity radiculopathy, bilateral peroneal neuropathy, bilateral knee internal derangement, right greater than left, left ankle traumatic arthritis, reactionary depression, anxiety, medication induced progress gastritis, non-insulin-dependent diabetes mellitus, industrially related, bilateral ulnar nerve entrapment, medication induced gastritis. A claim was placed for multiple medications.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**Norco 10/325mg #240:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 79.

**Decision rationale:** Norco 10/325 mg #240 is not medically necessary. Per MTUS Page 79 of MTUS guidelines states that weaning of opioids are recommended if (a) there are no overall improvement in function, unless there are extenuating circumstances (b) continuing pain with evidence of intolerable adverse effects (c) decrease in functioning (d) resolution of pain (e) if serious non-adherence is occurring (f) the patient requests discontinuing. The claimant's medical

records did not document that there was an overall improvement in function or a return to work with previous opioid therapy. The claimant has long-term use with this medication and there was a lack of improved function with this opioid; therefore the requested medication is not medically necessary.

**Anaprox DS 550mg #60:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

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

**Decision rationale:** Anaprox DS 500 mg #60 is not medically necessary. Per MTUS guidelines page 67, NSAIDS are recommended for osteoarthritis at the lowest dose for the shortest period in patients with moderate to severe pain so to prevent or lower the risk of complications associated with cardiovascular disease and gastrointestinal distress. The medical records do not document the length of time the claimant has been on Anaprox. Additionally, the claimant had previous use of NSAIDs. The medication is therefore not medically necessary.

**Prilosec 20mg #60:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

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

**Decision rationale:** Prilosec 20mg # 60 is not medically necessary. CA MTUS does not make a direct statement on proton pump inhibitors (PPI) but in the section on NSAID use page 67. Long term use of PPI, or misoprostol or Cox-2 selective agents have been shown to increase the risk of Hip fractures. CA MTUS does state that NSAIDs are not recommended for long term use as well and if there possible GI effects of another line of agent should be used for example acetaminophen; therefore, the requested medication is not medically necessary.

**Fexmid 7.5mg #60:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Cyclobenzaprine.

**Decision rationale:** Fexmid 7.5mg #60 is not medically necessary. is not medically necessary for the client's chronic medical condition. Fexmid is cyclobenzaprine. The peer-reviewed medical literature does not support long-term use of cyclobenzaprine in chronic pain

management. Additionally, Per CA MTUS Cyclobenzaprine is recommended as an option, using a short course of therapy. The effect is greatest in the first 4 days of treatment, suggesting that shorter courses may be better. (Browning, 2001). As per MTUS, the addition of cyclobenzaprine to other agents is not recommended. In regards to this claim, cyclobenzaprine was prescribed for long term use and in combination with other medications. Cyclobenzaprine is therefore, not medically necessary.