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| Case Number: | CM15-0100801 | | |
| Date Assigned: | 06/03/2015 | Date of Injury: | 08/16/2013 |
| Decision Date: | 07/01/2015 | UR Denial Date: | 04/27/2015 |
| Priority: | Standard | Application Received: | 05/26/2015 |

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: Family Practice

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 57-year-old female, who sustained an industrial injury on 08/16/2013. She reported injuring her lower back and buttocks after a fall while at work. The injured worker is currently not working. The injured worker is currently diagnosed as having chronic low back pain complaints, L3-4 and L5 facet arthropathy, L4-5 and L5S1 foraminal stenosis, right sacroiliitis, right pseudoarthrosis at L4-5, and right clinical radiculitis. Treatment and diagnostics to date has included lumbar spine MRI that showed retrolisthesis of L4-5 with narrowing and mild right L4-L5 pedicle/posterior element edema, physical therapy, chiropractic treatment, lumbar support brace, epidural steroid injection, and medications. In a progress note dated 04/13/2015, the injured worker presented with complaints of pain in her low back and buttocks and rated her pain a 9 out of 10 on the pain scale. Objective findings include lumbar tenderness. The treating physician reported requesting authorization for laboratory tests, Tramadol, and Naproxen.

IMR ISSUES, DECISIONS AND RATIONALES

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

Labs CBC, Hepatic Panel, CRP, Chem 8, UA, Arthritis Panel, CPK: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Website: www.nim.nih.gov.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Choosing Wisely: An Initiative of the ABIM Foundation <http://www.choosingwisely.org>.

Decision rationale: The MTUS/ACOEM and Official Disability Guidelines are silent on the issue in this case; specifically, the need for screening laboratory tests to include a CBC, Hepatic Panel, CRP, Chem 8, UA, Arthritis Panel and CPK. The most relevant resource for this question is from the recently published Choosing Wisely Campaign; an Initiative of the ABIM Foundation. The purpose of this initiative is, in part, to advise physicians on the appropriate use of laboratory testing in the evaluation of patients for a wide variety of conditions. In this case, the records indicate that the patient had normal laboratory tests for hepatic function and renal function in November 2014. There is no indication in the records that the patient's condition has changed since the time of these last laboratory tests. Further, there is no evidence in the medical records that any of these above requested tests are justified. For the use of a CBC, there is no documentation in the records for symptoms suggestive of anemia or that the patient was having signs of bleeding. For the use of a hepatic panel, the prior hepatitis panel was normal and the records indicate no history of liver disease. For the use of a CRP, an indicator of inflammation particularly in a patient with an autoimmune disease, there is no evidence to suggest that this patient is being evaluated for or has symptoms or exam findings suggestive of an autoimmune arthritis. For the use of a Chem 8 Panel, there is no documentation in the record of any medication that would affect the patient's electrolytes. Further, the patient had a recent creatinine level in November 2014, which was normal. For the use of a UA, there is no evidence in the records that the patient has a urinary symptom that requires an assessment for the presence of an infection. For the use of an arthritis panel, there is no evidence in the record that the patient has symptoms consistent with an autoimmune form of arthritis; the type of arthritis that is screened for in this blood test. Finally, for a CPK, there is no evidence in the record that the patient has symptoms of a myopathy, a muscle disorder that would be assessed by this test. For these reasons, the laboratory tests to include: CBC, Hepatic Panel, CRP, Chem 8, UA, Arthritis Panel and CPK is not medically necessary.

Tramadol 50 MG #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 76-78, 80.

Decision rationale: The MTUS/Chronic Pain Medical Treatment Guidelines comment on the long-term use of opioids, including Tramadol. These guidelines have established criteria of the use of opioids for the ongoing management of pain. Actions should include: prescriptions from a single practitioner and from a single pharmacy. The lowest possible dose should be prescribed to improve pain and function. There should be an ongoing review and 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. There should be evidence of documentation of the "4 A's for Ongoing Monitoring." These four domains include: pain relief, side effects, physical and psychological functioning, and the occurrence of any potentially aberrant drug-related behaviors. Further, there should be consideration of a consultation with a multidisciplinary pain clinic if doses of opioids are required beyond what is usually required for the condition or pain that does not improve on opioids in 3 months. There should be consideration of an addiction medicine consult if there is evidence of substance misuse (Pages 76-78). Finally, the guidelines indicate that for chronic pain, the long-term efficacy of opioids is unclear. Failure to respond to a time-limited course of opioids has led to the suggestion of reassessment and consideration of alternative therapy (Page 80). Based on the review of the medical records, there is insufficient documentation in support of these stated MTUS/Chronic Pain Medical Treatment Guidelines for the ongoing use of opioids. There is insufficient documentation of the "4 A's for Ongoing Monitoring." The treatment course of opioids in this patient has extended well beyond the timeframe required for a reassessment of therapy. In summary, there is insufficient documentation to support the chronic use of an opioid in this patient. Treatment with Tramadol is not considered as medically necessary.

Naproxen 500 MG #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): 67-68.

Decision rationale: The MTUS/Chronic Pain Medical Treatment Guidelines comment on the use of NSAIDs for chronic pain. Overall, these MTUS recommendations state that NSAIDs are primarily used for short-term relief of symptoms. Their specific recommendations are as follows: Osteoarthritis (including knee and hip): Recommended 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. NSAIDs appear to be superior to acetaminophen, particularly for patients with moderate to severe pain. There is no evidence to recommend one drug in this class over another based on efficacy. In particular, there appears to be no difference between traditional NSAIDs and COX-2 NSAIDs in terms of pain relief. The main concern of selection is based on adverse effects. COX-2 NSAIDs have fewer GI side effects at the risk of increased cardiovascular side effects, although the FDA has concluded that long-term clinical trials are best interpreted to suggest that cardiovascular risk occurs with all NSAIDs and is a class effect (with naproxyn being the safest drug). There is no evidence of long-term effectiveness for pain or function. Back Pain, Acute exacerbations of chronic pain: Recommended as a second-line treatment after acetaminophen. In general, there is conflicting evidence that NSAIDs are more effective than acetaminophen for acute LBP. Back Pain,

Chronic low back pain: Recommended as an option for short-term symptomatic relief. A Cochrane review of the literature on drug relief for low back pain (LBP) suggested that NSAIDs were no more effective than other drugs such as acetaminophen, narcotic analgesics, and muscle relaxants. The review also found that NSAIDs had more adverse effects than placebo and acetaminophen but fewer effects than muscle relaxants and narcotic analgesics. In addition, evidence from the review suggested that no one NSAID, including COX-2 inhibitors, was clearly more effective than another. In this case, the records indicate that Naproxen, the NSAID chosen for this patient, is intended as part of a long-term treatment strategy. The above-cited guidelines do not recommend NSAIDs for long-term use. There is insufficient documentation providing a rationale to depart from these cited guidelines. For this reason, Naproxen is not medically necessary.