

Case Number:	CM15-0169951		
Date Assigned:	09/10/2015	Date of Injury:	01/11/2005
Decision Date:	10/08/2015	UR Denial Date:	08/20/2015
Priority:	Standard	Application Received:	08/28/2015

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: North Carolina

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 45 year old female, who sustained an industrial injury on 1-11-05. The injured worker was diagnosed as having sprain-strain of left knee, sprain-strain of left ankle, lumbar disc bulges, pain in lower leg joint, pain in pelvis-thigh joint, muscle spasm and lumbosacral spondylosis. Treatment to date has included arthroscopic knee surgery, oral medications including Nucynta, Celebrex, Ultram and Norco and injections. Documentation did not include reports of (MRI) magnetic resonance imaging of lumbar spine or bilateral knees; however the provider noted on 6i-11-15 (MRI) magnetic resonance imaging of right hip revealed moderate right and mild left gluteal insertional strains, (MRI) magnetic resonance imaging of lumbar spine on 6-15 revealed disc bulges and bilateral facet joint hypertrophy and (MRI) magnetic resonance imaging of right and left knee performed on 4-23-15 noted severe patellofemoral chondromalacia. Currently on 8-4-15, the injured worker complains of low back, right hip and knee pain rated 5 out of 10 with medications and 9 out of 10 without medications, which is unchanged from previous visit of 7-14-15. She notes the pain is constant and radiating, increased by sitting, walking and cold weather. She is not working and disability status is noted to be permanent and stationary. On 7-14-15 physical exam noted she arises slowly from a seated position, well healed arthroscopy portals in both knee and restricted range of motion of knees due to pain. The treatment plan included requests for Norco 10-325mg #60, Tramadol 50mg #60, Celebrex 200mg #30, Nucynta ER100mg #60, request for Synvisc, ortho consult and request for GT bursa injection. On 8-20-15 utilization review non-certified Tramadol 50mg #60 noting lack of documentation to support current urine drug screen, risk assessment profile and

updated pain contract and non-certified Celebrex 200mg #30 noting lack of documentation of functional gains from previous use of the medication.

IMR ISSUES, DECISIONS AND RATIONALES

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

Tramadol 50mg, #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids for chronic pain.

Decision rationale: The California chronic pain medical treatment guidelines section on opioids states for ongoing management: On-Going Management. Actions Should Include: (a) Prescriptions from a single practitioner taken as directed, and all prescriptions from a single pharmacy. (b) The lowest possible dose should be prescribed to improve pain and function. (c) Office: 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. Information from family members or other caregivers should be considered in determining the patient's response to treatment. The 4 A's for Ongoing Monitoring: Four domains have been proposed as most relevant for ongoing monitoring of chronic pain patients on opioids: pain relief, side effects, physical and psychosocial functioning, and the occurrence of any potentially aberrant (or non-adherent) drug-related behaviors. These domains have been summarized as the "4 A's" (analgesia, activities of daily living, adverse side effects, and aberrant drug taking behaviors). The monitoring of these outcomes over time should affect therapeutic decisions and provide a framework for documentation of the clinical use of these controlled drugs. (Passik, 2000) (d) Home: To aid in pain and functioning assessment, the patient should be requested to keep a pain diary that includes entries such as pain triggers, and incidence of end-of-dose pain. It should be emphasized that using this diary will help in tailoring the opioid dose. This should not be a requirement for pain management. (e) Use of drug screening or inpatient treatment with issues of abuse, addiction, or poor pain control. (f) Documentation of misuse of medications (doctor-shopping, uncontrolled drug escalation, drug diversion). (g) Continuing review of overall situation with regard to non-opioid means of pain control. (h) 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 does not improve on opioids in 3 months. Consider a psych consult if there is evidence of depression, anxiety or irritability. Consider an addiction medicine consult if there is evidence of substance misuse. When to Continue Opioids: (a) If the patient has returned to work; (b) If the patient has improved functioning and pain (Washington, 2002) (Colorado, 2002) (Ontario, 2000) (VA/DoD, 2003) (Maddox-AAPM/APS, 1997) (Wisconsin, 2004) (Warfield, 2004). The long-term use of this medication class is not recommended per the California MTUS unless there documented

evidence of benefit with measurable outcome measures and improvement in function. There is documented significant improvement in VAS scores for significant periods of time. There are no objective measurements of improvement in function. Therefore not all criteria for the ongoing use of opioids have been met and the request is not medically necessary.

Celebrex (Celecoxib) 200mg #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): NSAIDs, specific drug list & adverse effects.

Decision rationale: The California chronic pain medical treatment guidelines section on NSAID use and proton pump inhibitors (PPI) states: Clinicians should weight the indications for NSAIDs against both GI and cardiovascular risk factors. Determine if the patient is at risk for gastrointestinal events: (1) age > 65 years; (2) history of peptic ulcer, GI bleeding or perforation; (3) concurrent use of ASA, corticosteroids, and/or an anticoagulant; or (4) high dose/multiple NSAID (e.g., NSAID + low-dose ASA). Recent studies tend to show that H. Pylori does not act synergistically with NSAIDs to develop gastroduodenal lesions. Recommendations Patients with no risk factor and no cardiovascular disease: Non-selective NSAIDs OK (e.g., ibuprofen, naproxen, etc.) Patients at intermediate risk for gastrointestinal events and no cardiovascular disease: (1) A non-selective NSAID with either a PPI (Proton Pump Inhibitor, for example, 20 mg omeprazole daily) or misoprostol (200 ug four times daily) or (2) a Cox-2 selective agent. Long-term PPI use (> 1 year) has been shown to increase the risk of hip fracture (adjusted odds ratio 1.44). Patients at high risk for gastrointestinal events with no cardiovascular disease: A Cox-2 selective agent plus a PPI if absolutely necessary. Cardiovascular disease: A non-pharmacological choice should be the first option in patients with cardiac risk factors. It is then suggested that acetaminophen or aspirin be used for short-term needs. An opioid also remains a short-term alternative for analgesia. Major risk factors (recent MI, or coronary artery surgery, including recent stent placement): If NSAID therapy is necessary, the suggested treatment is naproxen plus low-dose aspirin plus a PPI. Mild to moderate risk factors: If long-term or high-dose therapy is required, full-dose naproxen (500 mg twice a day) appears to be the preferred choice of NSAID. If naproxen is ineffective, the suggested treatment is (1) the addition of aspirin to naproxen plus a PPI, or (2) a low-dose Cox-2 plus ASA. Cardiovascular risk does appear to extend to all non-aspirin NSAIDs, with the highest risk found for the Cox-2 agents. (Johnsen, 2005) (Lanas, 2006) (Antman, 2007) (Laine, 2007) Use with Aspirin for cardio protective effect: In terms of GI protective effect: The GI protective effect of Cox-2 agents is diminished in patients taking low-dose aspirin and a PPI may be required for those patients with GI risk factors. (Laine, 2007) in terms of the actual cardio protective effect of aspirin: Traditional NSAIDs (both ibuprofen and naproxen) appear to attenuate the anti-platelet effect of enteric-coated aspirin and should be taken 30 minutes after ASA or 8 hours before. (Antman, 2007) Cox-2 NSAIDs and diclofenac (a traditional NSAID) do not decrease anti-platelet effect. (Laine, 2007) The patient does not have risk factors that would require a COX-2 inhibitor over a traditional NSAID. Therefore the request is not medically necessary.

