

Case Number:	CM15-0186402		
Date Assigned:	09/28/2015	Date of Injury:	12/10/2005
Decision Date:	11/03/2015	UR Denial Date:	09/14/2015
Priority:	Standard	Application Received:	09/22/2015

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 59-year-old male, with a reported date of injury of 12-10-2005. The diagnoses include left knee sprain, left knee chondromalacia of the patellofemoral joint and medial compartment, left knee posterior horn medial meniscus tear, and status post L4-5 fusion. Treatments and evaluation to date have included Norco (since at least 01-2015), Axid (since at least 01-2015), Neurontin, Fexmid (since at least 01-2015), lumbar spine fusion on 05-23-2012, post-operative rehabilitative therapy, cortisone injection in the medial plica on 06-20-2014 (minimal benefit), and viscosupplementation injection. The diagnostic studies to date have included an ultrasound of the left knee on 06-05-2015, which showed no abnormalities. The progress report dated 07-20-2015 indicates that the injured worker presented for final re-examination with complaints of increased low back pain. It was noted that electrodiagnostic studies of the bilateral lower extremities on 04-09-2013 were negative for lumbar radiculopathy or peripheral neuropathy; and a CT myelogram of the lumbar spine on 05-09-2013 showed mild facet hypertrophy from L2-4, partial fusion at L4-5, and sacroiliac joint osteoarthritis. The treating physician noted that the injured worker was recommended to get a spinal cord stimulator; however, the injured worker was not interested in proceeding with a trial. The injured worker also had a flare-up of his left knee. X-rays of the left knee on 11-22-2013 had normal findings, and an MRI of the left knee on 04-04-2014 showed mild tricompartmental osteoarthritis with grade 2 signal in the medial meniscus. The physical examination of the lumbar spine showed a well-healed surgical scar; tenderness to palpation with muscle guarding over the paraspinal musculature, bilaterally; right-sided low back pain with straight leg raise test; and decreased lumbar range of motion. An examination of the left knee showed no evidence of

swelling, atrophy, or deformity; tenderness to palpation over the medial joint line, lateral joint line, peripatellar region and distal quadriceps; patellofemoral crepitus with passive ranging; pain with McMurray's test; positive patellar grind test; left knee flexion at 110 degrees; left knee extension at 0 degrees; decreased sensation to pinprick and light touch in the bilateral lower extremities along the left L5 and S1 dermatomes; weakness of the left knee flexor and extensor muscles; and use of a single point cane favoring the left lower extremity. The injured worker's condition is considered permanent and stationary. The treating physician requested Norco 10-325mg #120, Axid 150mg #60, and Fexmid 10mg #60. On 09-14-2015, Utilization Review (UR) non-certified the request for Norco 10-325mg #120, Axid 150mg #60, and Fexmid 10mg #60.

IMR ISSUES, DECISIONS AND RATIONALES

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

Norco 10/325mg #120: 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 no documentation of significant subjective improvement in pain such as VAS scores. There is also no objective measure of improvement in function. For these reasons, the criteria set forth above of ongoing and continued used of opioids have not been met. Therefore, the request is not medically necessary.

Axid 150mg #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 Medical Treatment 2009, Section(s): NSAIDs, GI symptoms & cardiovascular risk.

Decision rationale: The California chronic pain medical treatment guidelines section on NSAID therapy and proton pump inhibitors (PPI) states: Recommend with precautions as indicated below. 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 a anti-coagulant; 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 gastro duodenal 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 mg 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. There is no documentation provided that places this patient at low, intermediate or high risk that would justify the use of a H2 blocker. There is no mention of current gastrointestinal or cardiovascular disease. For these reasons, the criteria set forth above per the California MTUS for the use of this medication has not been met. Therefore, the request is not medically necessary.

Fexmid 10mg #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 Medical Treatment 2009, Section(s): Muscle relaxants (for pain).

Decision rationale: The California chronic pain medical treatment guidelines section on muscle relaxants states: Recommend non-sedating muscle relaxants with caution as a second-line option for short-term treatment of acute exacerbations in patients with chronic LBP. (Chou, 2007) (Mens, 2005) (Van Tulder, 1998) (Van Tulder, 2003) (Van Tulder, 2006) (Schnitzer, 2004) (See, 2008) Muscle relaxants may be effective in reducing pain and muscle tension, and increasing

mobility. However, in most LBP cases, they show no benefit beyond NSAIDs in pain and overall improvement. Also there is no additional benefit shown in combination with NSAIDs. Efficacy appears to diminish over time, and prolonged use of some medications in this class may lead to dependence. (Homik, 2004) (Chou, 2004) This medication is not intended for long-term use per the California MTUS. The medication has not been prescribed for the flare-up of chronic low back pain but rather ongoing knee pain. This is not an approved use for the medication. For these reasons, criteria for the use of this medication have not been met. Therefore, the request is not medically necessary.