

<b>Case Number:</b>	CM15-0200536		
<b>Date Assigned:</b>	10/15/2015	<b>Date of Injury:</b>	10/23/2009
<b>Decision Date:</b>	11/24/2015	<b>UR Denial Date:</b>	09/14/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/13/2015

### 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 47 year old female, who sustained an industrial injury on 1-23-09. The injured worker was diagnosed as having lumbar spondylosis; lumbar degenerative disc disease; lumbar HNP L1-2; lumbar radiculopathy; opioid induced constipation. Treatment to date has included physical therapy; TENS unit; pain psychologist; lumbar translaminar epidural steroid injection L5-S1 - epidurogram (1-12-15; 8-31-15); medications. Diagnostics studies included MRI lumbar spine 8-1-14). Currently, the PR-2 notes dated 8-31-15 indicated the injured worker returns to the clinic and was last seen on 6-25-15. The provider documents "The patient's most recent urine drug screen from 4-2-15 did not detect any illicit drug or alcohol abuse. She continues to experience chronic bilateral low back pain with radiation into both lower extremities. She complains of cramping and spasm in both legs. Prolonged sitting, standing, walking aggravates the pain. She underwent a lumbar epidural steroid injection this morning. She is currently rating her pain a 5-6 out of 10 on the VAS." He notes she is averaging 3 tablets of Tramadol daily to manage her pain. He documents "Tramadol can reduce her pain from 8-10 out of 10 to 4 out of 10 which is tolerable. The Lyrica helps reduce the neuropathic pain by 30-50%. The Tramadol and Lyrica enable her to perform activities of daily living including cleaning, cooking, vacuuming, walking and spending time with her family. The Prilosec helps the nausea and heartburn related to chronic medication use. Amitiza is helpful in reducing constipation." On physical examination; the provider documents "She has severely limited lumbar flexion and extension. There is mild lumbar paraspinal muscle tenderness bilaterally. There is weakness with left ankle dorsiflexion and EHL. She has difficulty when standing on toes. There is diminished sensation to light touch throughout the left lower

extremity. Deep tendon reflexes depressed on left compared to right. Positive straight leg raise bilaterally." The provider notes a lumbar spine MRI dated 8-1-14 with impression "6 non-rib bearing lumbar type vertebral bodies seen with las lumbar type vertebral body designated as L5 L5-S1 mild degenerative disc changes, annular bulging and mild facet joint arthrosis contributing to mild bilateral foraminal stenosis, L4-L5 mild degenerative disc changes and small central disc protrusion with underlying annular fissure. L1-L2 focal far left lateral disc protrusion with underlying annular fissure." The treatment plan is for the injured worker to continue her medications and he notes he is unable to find CURES report for the prescribed medications and will contact the pharmacy. She is to also follow-up with pain psychologist. Refill: Ultram 50mg #120, Lyrica 150mg #60, Amitiza 24mcg #60; Prilosec 20mg #30. A PR-2 dated 5-28-15 indicates the injured worker had a lumbar epidural steroid injection on 1-12-15 with 70% benefit of pain relief. Pain on this date is documented by the provider as "She currently rates her pain as 6-7 out of 10 on the VAS. Denies any new changes in pain since the last visit." No change in prescribed medications or dosage or treatment palm. He notes he reviewed a CURES report with no other comments or date of report. A Request for Authorization is dated 10-13-15. A Utilization Review letter is dated 9-14-15 and non-certification for Ultram 50 MG #120; Lyrica 150 MG #60 and Prilosec 20 MG #30. A request for authorization has been received for Ultram 50 MG #120; Lyrica 150 MG #60 and Prilosec 20 MG #30.

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

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

**Ultram 50 MG Qty 120:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids, criteria for use.

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

**Decision rationale:** 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 documentation of significant subjective improvement in pain such as VAS scores with pain reduced from an 8/10 to a 4/10. There is no objective measure of improvement in function or activities due to medication. Work status is not mentioned. For these reasons all the criteria set forth above of ongoing and continued used of opioids have not been met. Therefore the request is not medically necessary.

**Lyrica 150 MG Qty 60:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Antiepilepsy drugs (AEDs).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Antiepilepsy drugs (AEDs).

**Decision rationale:** The California chronic pain medical treatment guidelines section on Lyrica states: Pregabalin (Lyrica, no generic available) has been documented to be effective in treatment of diabetic neuropathy and post herpetic neuralgia, has FDA approval for both indications, and is considered first-line treatment for both. This medication is designated as a Schedule V controlled substance because of its causal relationship with euphoria. (Blommel, 2007) This medication also has an anti-anxiety effect. Pregabalin is being considered by the FDA as treatment for generalized anxiety disorder and social anxiety disorder. In June 2007 the FDA announced the approval of pregabalin as the first approved treatment for fibromyalgia. (ICSI, 2007) (Tassone, 2007) (Knotkova, 2007) (Eisenberg, 2007) (Crofford, 2005) (Stacey, 2008) The patient does not have the diagnoses of diabetic neuropathy, fibromyalgia or post herpetic neuropathy. There is no documentation of failure of other first line agents for peripheral neuropathy pain that the patient is experiencing. Therefore guideline recommendations have not been met and the request is not medically necessary.

**Prilosec 20 MG Qty 30:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), PPIs.

**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 here. 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 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 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 (200g 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 intermediate or high risk that would justify the use of a PPI. There is no mention of current gastrointestinal or cardiovascular disease besides nausea and heartburn. 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.