

<b>Case Number:</b>	CM15-0026826		
<b>Date Assigned:</b>	02/19/2015	<b>Date of Injury:</b>	04/29/2002
<b>Decision Date:</b>	04/07/2015	<b>UR Denial Date:</b>	02/09/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/12/2015

### 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: Physical Medicine & Rehabilitation

### 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 male who sustained a work related injury April 29, 2002. He was struck from behind by a forklift, pinning him to the rear of his truck. His immediate complaints were that of the left lower leg and knee pain and advanced to lower back pain, hip and pelvis pain with diffuse bruising across the pelvis and groin area, mid back pain, neck pain and left shoulder pain. According to the primary treating physician's report dated January 21, 2015, the injured worker presented for back pain described as moderate-severe and rated 9/10 without medication and 6/10 with medication. He is current and consistent with his random and routine testing and opiate agreement is up to date. Assessment is documented as chronic depression/anxiety; hypogonadism; chronic cervical strain; chronic pain syndrome; chronic facet arthropathy; and chronic cervical degenerative disc disease. Treatment plan included request for medications. Work status is documented as permanent and stationary. According to utilization review dated February 9, 2015, the request for Celebrex 200mg #30, (4) Refills has been modified to Celebrex 200mg #20, no Refills, citing MTUS Chronic Pain Medical Treatment Guidelines. The request for Methadone HCL 10mg #120 has been modified to Methadone HCL 10mg # 90, citing MTUS Chronic Pain Medical Treatment Guidelines. The request for Prilosec 20mg #30, (1) Refill is non-certified, citing MTUS Chronic Pain Medical Treatment Guidelines. The request for Androgel 50mg/5gram (1%) packet #30, (4) Refills is non-certified, citing MTUS Chronic Pain Medical Treatment Guidelines.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Celebrex 200 mg, thirty count with four refills:** Overturned

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 70.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines anti-inflammatory medications Medications for chronic pain Page(s): 22, 60.

**Decision rationale:** This patient presents with neck, low back, and left knee pain. The treater is requesting CELEBREX 200 MG 30 COUNT WITH 4 REFILLS. The RFA dated 01/21/2015 shows a request for Celebrex 200 mg 1 p.o. q.d. p.r.n. pain, #30, 4 refills. The patient's date of injury is from 04/29/2002, and he is currently permanent and stationary. The MTUS Guidelines page 22 on anti-inflammatory medication states that anti-inflammatories are the traditional first-line treatment to reduce pain so activity and functional restoration can resume, but long term use may not be warranted. MTUS page 60 on medications for chronic pain states that pain assessment and functional changes must also be noted when medications are used for chronic pain. The records show that the patient was prescribed Celebrex on 11/20/2014. The 01/21/2015 report notes that the patient continues to benefit from his current medications to the extent that he is able to raise his children along with his estranged wife. It was further noted that without medication, his pain level is at 9/10; and with medication use, at 6/10. In this case, the treater has noted medication efficacy and the continued use of Celebrex is supported by the guidelines. The request IS medically necessary.

**Methadone HCL 10 mg, 120 count:** Overturned

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 9, 74, and 78 - 97.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines criteria for use of opioids Page(s): 76-78, 88-89.

**Decision rationale:** This patient presents with neck, low back, and left knee pain. The treater is requesting METHADONE HCL 10 MG 120 COUNT. The RFA dated 01/21/2015 shows a request for methadone HCl 10 mg 1 p.o. q.i.d. for pain, #120, 0 refills. The patient's date of injury is from 04/29/2002, and he is currently permanent and stationary. For chronic opiate use, the MTUS guidelines page 88 and 89 on criteria for use of opioids states, "pain should be assessed at each visit, and functioning should be measured at six-month intervals using a numerical scale or validated instrument." MTUS page 78 On-Going Management also require documentation of the "4A's" including analgesia, ADLs, adverse side effects, and aberrant drug seeking behavior, as well as "pain assessment" or outcome measures that include current pain, average pain, least pain, intensity of pain after taking the opioid, time it takes for medications to work, and duration of pain relief. The records show that the patient was prescribed methadone on 06/03/2014. The 01/21/2015 report notes that the patient's pain level without medication use is 9/10, and 6/10 with medication use. He denies any side effects, and no aberrant drug-seeking

behavior was noted. The patient states that he does struggle, but he still fulfills his daily home responsibilities with the use of medications. Without the use of medications, he has to stay in bed at least half the day with no contact of the outside world. His CURES report and opiate agreement are both up to date. In this case, the patient has met the required criteria for continued opiate use. The request IS medically necessary.

**Prilosec 20 mg, thirty count with one refill:** Overturned

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 68.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms, and cardiovascular risks Page(s): 69.

**Decision rationale:** This patient presents with neck, low back, and left knee pain. The treater is requesting PRILOSEC 20 MG #30 COUNT WITH 1 REFILL. The RFA dated 01/21/2015 shows a request for Prilosec 20 mg to take 1 capsule 20 mg by oral route every day before meal, #30 with 1 refill. The patient's date of injury is from 04/29/2002, and he is currently permanent and stationary. The MTUS Guidelines page 68 and 69 on NSAIDs, GI symptoms, and cardiovascular risks states, " 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." MTUS also states, "Treatment of dyspepsia secondary to NSAID therapy: Stop the NSAID, switch to a different NSAID, or consider H2-receptor antagonists or a PPI." The records show that the patient was prescribed Prilosec on 07/02/2014. The records show that the patient has a history of gastritis. In this case, the treater has noted gastrointestinal issues, and the continued use of Prilosec is supported by the guidelines. The request IS medically necessary.

**Androgel 50 mg/5 grams (1%) packet, thirty count with four refills:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 110. Decision based on Non-MTUS Citation Harrison's Principles of Internal Medicine 14th Edition, Opioid Drug Use: The Acute and Chronic Effects of Opioid Drugs on the Body Systems Chapter, pages 2152 - 2154.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official disability guidelines Pain chapter on testosterone replacement treatments.

**Decision rationale:** This patient presents with neck, low back, and left knee pain. The treater is requesting ANDROGEL 50 MG/5 G 1% PACKET #30 COUNT WITH 4 REFILLS. The RFA dated 01/21/2015 shows a request for AndroGel 50 mg/5 g 1% apply 1 packet by topical route every day, #30, 4 refills. The patient's date of injury is from 04/29/2002, and he is currently permanent and stationary. The MTUS and ACOEM Guidelines do not address this request.

However, ODG Guidelines under the Pain chapter on testosterone replacement treatments for hypogonadism states that it is recommended in limited circumstances for patients taking high-dose, long-term opioids with documented low-testosterone levels. Hypogonadism has been noted in patients receiving intrathecal opioids and long-term, high-dose opioids. The records show that the patient was prescribed AndroGel on 04/10/2014. The patient's current list of medications includes methadone, AndroGel, Celebrex, and Prilosec. The records show that the patient has a diagnosis of hypogonadism. There is no discussion as to the patient's current testosterone levels. None of the reports discuss low testosterone levels. In this case, the patient does not meet the required criteria based on the ODG Guidelines for AndroGel. The requested IS NOT medically necessary.