

<b>Case Number:</b>	CM15-0036071		
<b>Date Assigned:</b>	03/04/2015	<b>Date of Injury:</b>	12/27/2007
<b>Decision Date:</b>	04/14/2015	<b>UR Denial Date:</b>	02/10/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/25/2015

### 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: New Jersey, Michigan, California  
 Certification(s)/Specialty: Neurology, Neuromuscular Medicine

### 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 34 year old female, who sustained an industrial injury on December 27, 2007. She has reported a low back injury. The diagnoses have included lumbar radiculopathy, and lumbar myofascial strain. Treatment to date has included medications, and physical therapy. Currently, the IW complains of low back pain. She rates her pain as 7/10, and feels her pain has increased from a previous examination. She reports the pain radiates into her hips and legs, causing her to lose sleep. She indicates medications help. Physical findings reveal loss of sensation in the dorsum of the left foot, and positive nerve root tension signs. She has limited range of motion, and a normal gait. The records indicate a magnetic resonance imaging on March 18, 2014, reveals mild stable disc bulging at L4-5, and diffuse disc bulging at L5-S1. On February 10, 2015, Utilization Review non-certified Nortriptyline 10mg #60, and Ketoprofen 75mg #60 with 2 refills; and modified certification of Norco 10/325mg #30. The MTUS, Chronic Pain Medical Treatment guidelines were cited. On February 23, 2015, the injured worker submitted an application for IMR for review of Nortriptyline 10mg #60, and Ketoprofen 75mg #60 with 2 refills, and Norco 10/325mg #90.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Nortriptyline 10mg #60:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressant for chronic pain Page(s): 13.

**Decision rationale:** According to MTUS guidelines, tricyclics (Nortriptyline is a tricyclic antidepressant) are generally considered as a first a first line agent for pain management unless they are ineffective, poorly tolerated or contraindicated. According to the patient file, there is no documentation of a specific objective neuropathic pain condition occurring on physical examination. There is no documentation of diabetic neuropathy or post-herpetic neuralgia. Based on the above, the prescription for Nortriptyline 10mg #60 is not medically necessary.

**Ketoprofen 75mg #60 with 2 refills:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NONSELECTIVE NSAIDS Page(s): 107.

**Decision rationale:** According to MTUS guidelines, non-steroidal anti-inflammatory drugs (NSAIDs) are recommended in case of 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 (Chen, 2008) (Laine, 2008). 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. (van Tulder, 2006) (Hancock, 2007) For patients with acute low back pain with sciatica a recent Cochrane review (including three heterogeneous randomized controlled trials) found no differences in treatment with NSAIDs vs. placebo. In patients with axial low back pain this same review found that NSAIDs were not more effective than acetaminophen for acute low-back pain, and that acetaminophen had fewer side effects. (Roelofs-Cochrane, 2008) The addition of NSAIDs or spinal manipulative therapy does not appear to increase recovery in patients with acute low back pain over that received with acetaminophen treatment and advice from their physician. (Hancock, 2007) 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. (Roelofs-Cochrane, 2008) See also Anti-inflammatory medications. Neuropathic pain: There is inconsistent evidence for the use of these medications to treat long term neuropathic pain, but they may be useful to treat breakthrough and mixed pain conditions such as osteoarthritis (and other nociceptive pain) in with neuropathic pain. (Namaka, 2004) (Gore, 2006) See NSAIDs, GI symptoms & cardiovascular risk; NSAIDs, hypertension and renal function. Besides the above well-documented side effects of NSAIDs, there are other less well known effects of NSAIDs, and the use of NSAIDs has been shown to possibly delay and hamper healing in all the soft tissues, including muscles, ligaments, tendons, and cartilage. (Maroon, 2006) There is no documentation that the patient was treated with acetaminophen as a first line. In addition, there is no documentation of acute exacerbation of acute pain. The long-term use of NSAID drug may expose the risk of GI bleed and its efficacy is Questionable. Therefore, the prescription of Ketoprofen 75 mg, with 2 refills is not medically necessary.

**Norco 10/325mg #90:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for use of opioids Page(s): 76-79.

**Decision rationale:** According to MTUS guidelines, Norco (Hydrocodone/Acetaminophen) is a synthetic opioid indicated for the pain management but not recommended as a first line oral analgesic. In addition and according to MTUS guidelines, ongoing use of opioids should follow specific rules: (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. 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. According to the patient file, there is no objective documentation of pain and functional improvement to justify continuous use of Norco. Norco was used for longtime without documentation of functional improvement or evidence of return to work or improvement of activity of daily living. Therefore, the prescription of Norco 10/325mg #90 is not medically necessary.