

<b>Case Number:</b>	CM15-0053005		
<b>Date Assigned:</b>	03/26/2015	<b>Date of Injury:</b>	05/09/2009
<b>Decision Date:</b>	05/05/2015	<b>UR Denial Date:</b>	03/11/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/20/2015

### 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: Texas, California  
 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:

This is a 52 year old female patient who sustained an industrial injury on 5/9/09. The diagnoses include impingement syndrome of the right shoulder, internal derangement of the left knee, discogenic lumbar condition, and chronic pain syndrome. She sustained the injury due to slipped and fell incidence. Per the doctor's note dated 2/04/2015, she had complains of right shoulder, neck, low back and left knee pain. The physical examination revealed right shoulder- unable to lift more than 90 degrees. The medications list includes tramadol, trazodone, norco, lidoderm patch, lunesta and neurontin. She has undergone right shoulder arthroscopic surgery in 2013; left knee surgery in 2009. She has had diagnostic studies including lumbar MRI; right shoulder MR arthrogram and left knee MRI; EMG/NCS in 2010 which revealed L5-S1 radiculopathy. Treatments to date have included injections, knee brace, and transcutaneous electrical nerve stimulation unit.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Tramadol ER 150 mg #30:** Overturned

**Claims Administrator guideline:** Decision based on MTUS ACOEM, Chronic Pain Treatment Guidelines Page(s): 18, 56-57, 75-94, 98-99, 111-113.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page 75, Central acting analgesics Page 82, Opioids for neuropathic pain.

**Decision rationale:** Tramadol ER 150 mg #30. Tramadol is a centrally acting synthetic opioid analgesic. According to MTUS guidelines "Central acting analgesics: an emerging fourth class of opiate analgesic that may be used to treat chronic pain. This small class of synthetic opioids (e.g., Tramadol) exhibits opioid activity and a mechanism of action that inhibits the reuptake of serotonin and nor epinephrine. Central analgesics drugs such as Tramadol (Ultram) are reported to be effective in managing neuropathic pain. (Kumar, 2003)" Cited guidelines also state that, "A recent consensus guideline stated that opioids could be considered first-line therapy for the following circumstances: (1) prompt pain relief while titrating a first-line drug; (2) treatment of episodic exacerbations of severe pain; [&] (3) treatment of neuropathic cancer pain". Tramadol use is recommended for treatment of episodic exacerbations of severe pain. Per the records provided she had chronic shoulder and knee pain with history of shoulder and left knee surgeries. She is noted to have significant objective evidence of abnormalities on physical exam- limited shoulder range of motion. There is objective evidence of conditions that can cause chronic pain with episodic exacerbations. The request for Tramadol ER 150 mg #30 is medically appropriate and necessary to use as prn during acute exacerbations.

**Norco 325 mg #120:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM,Chronic Pain Treatment Guidelines Page(s): 18, 56-57, 75-94, 98-99, 111-113.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for use of Opioids Page 76-80.

**Decision rationale:** Norco contains hydrocodone and acetaminophen. Hydrocodone is an opioid analgesic. According to the cited guidelines, "A therapeutic trial of opioids should not be employed until the patient has failed a trial of non-opioid analgesics. Before initiating therapy, the patient should set goals, and the continued use of opioids should be contingent on meeting these goals". The records provided did not specify that that patient has set goals regarding the use of opioid analgesic. The treatment failure with non-opioid analgesics was not specified in the records provided. Other criteria for ongoing management of opioids are: "The lowest possible dose should be prescribed to improve pain and function. Continuing review of overall situation with regard to nonopioid means of pain control. Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects...Consider the use of a urine drug screen to assess for the use or the presence of illegal drugs". The records provided did not provide a documentation of response in regards to pain control and functional improvement to opioid analgesic for this patient. The continued review of the overall situation with regard to non-opioid means of pain control was not documented in the records provided. As recommended by the cited guidelines a documentation of pain relief, functional status, appropriate medication use, and side effects should be maintained for ongoing management of opioid analgesic, these were not specified in the records provided. Prior urine drug screen report was not specified in the

records provided. This patient did not meet criteria for ongoing continued use of opioids analgesic. The medical necessity of Norco 325 mg #120 is not established for this patient.

**Neurontin 600 mg #90:** Overturned

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 18, 56-57, 75-94, 98-99, 111-113.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page 18-19 Gabapentin (Neurontin, Gabarone, generic available).

**Decision rationale:** Gabapentin is an anti-epileptic drug. According to the CA MTUS Chronic pain guidelines "Gabapentin (Neurontin) has been shown to be effective for treatment of diabetic painful neuropathy and postherpetic neuralgia and has been considered as a first-line treatment for neuropathic pain". Per the cited guidelines, "CRPS: Recommended as a trial. (Serpell, 2002) Fibromyalgia: Recommended as a trial. (Arnold, 2007) Lumbar spinal stenosis: Recommended as a trial, with statistically significant improvement found in walking distance, pain with movement, and sensory deficit found in a pilot study". Per the records provided patient had chronic shoulder, left knee, neck and back pain with history of right shoulder and left knee surgery. Patient is having significant objective findings on physical examination- limited shoulder flexion. She has had EMG/NCS in 2010 which revealed L5-S1 radiculopathy. This is evidence of nerve related pain. Gabapentin is recommended in a patient with such a condition. This request for Neurontin 600 mg #90 is medically appropriate and necessary for this patient.