

<b>Case Number:</b>	CM14-0216025		
<b>Date Assigned:</b>	01/06/2015	<b>Date of Injury:</b>	02/12/2004
<b>Decision Date:</b>	03/03/2015	<b>UR Denial Date:</b>	11/25/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/23/2014

### 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:

This 50 year old female was an office/administrative assistant when she sustained an injury on February 12, 2004. She fell three feet from a bench as she went to sit down, injuring her right knee, buttocks and back. The diagnoses and results of the injury include right knee arthroscopic partial meniscectomy and chondroplasty in 2004, compensatory arthralgia of the left knee, back pain, status post disc replacement of L5-S1 (lumbar5-sacral1) in 2012, and bilateral carpal tunnel syndrome, compensatory from use of a cane. Past treatment included bilateral wrist braces, lumbosacral support, TENS (transcutaneous electrical nerve stimulation), right knee brace, walking with a cane, right knee Hyalgan injections and one left knee Hyalgan injection, lumbar epidural injection with relief, activity modifications, and non-steroidal anti-inflammatory, anti-epilepsy, muscle relaxant, proton pump inhibitor, short-acting and long-acting pain, anti-depressant, and sleep medications. On November 15, 2014, the treating physician noted the injured worker had good relief from a right knee Hyalgan injection in the previous year. The injured worker had low back and bilateral knee pain. She had with right knee swelling, popping, and clicking. There were similar symptoms on the left, but there right knee was more painful. She walked with use of a cane. The physical exam revealed bilateral knee tenderness, medial and lateral joint line with swelling more medially on the right knee than the left knee. The injured worker had an antalgic and wide-based gait, difficulty getting on and off the exam table, and pain across the lumbar spine with pain along the facet and with facet loading. Diagnoses were right knee partial meniscectomy and mild to moderate osteoarthritis - x-rays in 2013 revealed some articular surface on the left and tear in the posterior horn of the medical meniscus, discogenic

lumbar condition status post fusion at L5-S1 with chronic right L5 radiculopathy, bilateral carpal tunnel syndrome, compensatory left knee pain - MRI revealed tricompartmental arthritis and x-ray in 2013 revealed 1 mm articular surface on the left, and chronic pain syndrome. The injured worker was given a second left knee Hyalgan injection. The physician provided the injured worker with prescriptions for her current muscle relaxant, proton pump inhibitor, short-acting and long-acting pain, anti-depressant, and sleeps medications. The physician noted that the current medications provided 30% pain reduction, which helped the injured worker to be functional and able to do house chores. The physician recommended continuing to walk as tolerated. The injured worker was not currently working. On November 25, 2014, Utilization Review non-certified a prescription for Soma 300mg #90 and modified a prescription for Norco 10/325mg #100 requested on November 13, 2014. The Soma was non-certified based on the guidelines do not support its use for chronic pain. The most recent progress report did not indicate that spasms were present. A previous review certified an amount of Soma for weaning of the medication, and the injured worker should be completely weaned at this time. The Norco was modified based on the lack of functional goals to monitor the efficacy of the opioid therapy program, the injured worker's function continued to remain minimal despite multiple pharmacological agents prescribed to her over the long-term, the injured worker had not returned to work, and a previous review suggested weaning of the Norco which seems appropriate. The California Medical Treatment Utilization Schedule (MTUS), Chronic Pain Medical Treatment Guidelines for Hydrocodone/Acetaminophen (Anexsia, Hycet, Lortab; Margesic-H, Maxidone; Norco, Stagesic, Vicodin, Xodol, Zydone; generics available) and Soma (Carisoprodol) was cited.

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

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

**Norco 10/325 mg #100:** 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, Prospective request for 1 prescription of Norco 10/325mg #100 is not medically necessary.

**Soma 300 mg #90:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines SOMA, Page(s): 29.

**Decision rationale:** According to MTUS guidelines, a non sedating muscle relaxants is recommended with caution as a second line option for short term treatment of acute exacerbations in patients with chronic lumbosacral pain. Efficacy appears to diminish over time and prolonged use may cause dependence. According to the provided file, the patient was prescribed Soma a long time without clear evidence of spasm or excacerbation of neck and lumbar pain. There is no justification for prolonged use of Soma. The request for Soma 300mg #90 is not medically necessary.

**MS Contin 30 mg #30:** Upheld

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

**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, 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. There is no clear documentation of patient improvement in level of function, quality of life, adequate follow up for absence of side effects and aberrant behavior with a previous use of narcotics. The patient continues to have chronic pain despite the continuous use of narcotics. Therefore, the request for MS Contin 30 mg #30 is not medically necessary.

**Effexor 75 mg #60:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Effexor Page(s): 124.

**Decision rationale:** According to MTUS guidelines, Effexor is recommended as an option in first-line treatment of neuropathic pain. Venlafaxine (Effexor) is a member of the selective-serotonin and norepinephrine reuptake inhibitor (SNRIs) class of antidepressants. It has FDA approval for treatment of depression and anxiety disorders. It is off label recommended for treatment of neuropathic pain, diabetic neuropathy, fibromyalgia, and headaches. The initial dose is generally 37.5 to 75 mg/day with a usual increase to a dose of 75 mg b.i.d or 150 mg/day of the ER formula. The maximum dose of the immediate release formulation is 375 mg/day and of the ER formula is 225 mg/day. Effexor is generally considered after failure of tricyclic antidepressants or if they are poorly tolerated or contraindicated for treatment of chronic pain. Although the patient developed a chronic pain syndrome there is no clear indication that he is suffering from depression. There is no documentation of failure, intolerance or contraindication for tricyclic antidepressant to favor the use of Effexor. There is no documentation of the medical necessity to use Effexor and the modality to assess its efficacy and side effects. Therefore, the request for Effexor 75 mg #60 is not medically necessary.

**Trazodone 50 mg #60:** 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)

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Schwartz, T., et al. (2004). "A comparison of the effectiveness of two hypnotic agents for the treatment of insomnia". Int J Psychiatr Nurs Res 10(1): 1146-1150

**Decision rationale:** There is no clear evidence that the patient was diagnosed with major depression requiring Trazodone. There is no formal psychiatric evaluation documenting the diagnosis of depression requiring treatment with Trazodone. In addition, there is no recent documentation of insomnia. There is no documentation of failure of first line treatments for insomnia and depression. Therefore, the request for Trazodone 50mg is not medically necessary.

**Protonix 20 mg #60:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk Page(s): 68.

**Decision rationale:** According to MTUS guidelines, Omeprazole is indicated when NSAID are used in patients with intermediate or high risk for gastrointestinal events. The risk for gastrointestinal events are: (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. There is no documentation that the patient has GI issue that requires the use of prilosec. There is no documentation in the patient's chart supporting that she is at intermediate or high risk for developing gastrointestinal events. Therefore, Protonix 20mg prescription is not medically necessary.