

<b>Case Number:</b>	CM14-0036155		
<b>Date Assigned:</b>	06/23/2014	<b>Date of Injury:</b>	08/01/1993
<b>Decision Date:</b>	03/06/2015	<b>UR Denial Date:</b>	02/28/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/24/2014

### 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: Pennsylvania  
 Certification(s)/Specialty: Internal 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 53 year old male with a date of injury of 8/1/93. Diagnoses include cervical degenerative disc disease with facet arthropathy and bilateral upper extremity radiculopathy, thoracic spine sprain/strain, lumbar degenerative disc disease, facet arthropathy, foraminal narrowing, and bilateral lower extremity radiculopathy, peroneal neuropathy, bilateral knee internal derangement, left ankle traumatic arthritis, depression/anxiety, medication induced gastritis, diabetes, bilateral carpal tunnel syndrome, bilateral ulnar nerve entrapment, and myofascial pain. A neurology consultant documented on 9/10/13 that the injured worker has not worked since 9/1996. Work status as of February 2014 was not working, permanent and stationary. Primary treating physician progress note of 2/13/14 documents that the injured worker had complaints of pain in the low back rated 4/10 in severity, as well as ongoing right knee and left ankle pain. Examination showed antalgic gait and use of a single point cane, tenderness over the posterior cervical musculature with limited range of motion and muscle rigidity, decreased bilateral upper extremity sensation along the lateral arm and forearm, positive Tinel's sign bilaterally, diffuse muscle atrophy along the thenar and hypothenar muscles bilaterally, tenderness of the lumbar spine with muscle rigidity and decreased range of motion, decreased sensation along L5 distribution bilaterally, positive straight leg raise bilaterally, tenderness along the medial and lateral joint line of the right knee with mild crepitus and positive McMurray's sign, and swelling to the left ankle with tenderness to palpation and decreased range of motion. Treatment has included cervical and lumbar epidural steroid injections, left ankle surgeries, corticosteroid injection of the right knee and left ankle, viscosupplementation

injections to the right knee, trigger point injections, physical therapy, aqua therapy, consultations, psychological counselling, and medication management. Authorization for right knee arthroscopic meniscectomy was requested. Diagnostic tests have included magnetic resonance imaging (MRI) of the right knee, cervical spine, and lumbar spine, electrodiagnostic studies of the upper and lower extremities. The documentation submitted included progress reports from August 2013 to February 2014 with visits occurring approximately on a monthly basis and an orthopedic Agreed Medical Examination from February 2014. The submitted records indicate that the injured worker was prescribed Norco and anaprox from February 2013 through February 2014. It was noted that the injured worker had gastrointestinal distress while taking norco in conjunction with anaprox and required Prilosec for this; physician documentation also notes that Prilosec is being utilized for gastrointestinal protection due to the injured worker's risk factors. The documentation from the physician states that the injured worker is routinely monitored for "at risk" behavior with random drug screens and review and that the injured worker has a signed opioid treatment contract. A urine drug screen from 11/19/13 was submitted and was discussed in the physician progress notes. An additional urine drug screen from 9/20/13 was also submitted. It was documented on 2/13/14 that the epidural steroid injections allowed the injured worker to cut back on the amount of norco he takes on a daily basis, from 10 tablets per day to 6-8 tablets per day. Medications as of 2/13/14 included norco, ultram, anaprox, zanaflex, Prilosec, Xanax, trazodone, Lexapro, and dendracin cream. On 2/2/14, Utilization Review (UR) non-certified requests for Anaprox DS and Prilosec; requests for Ultram ER and Norco were modified in quantity for weaning. UR cited the MTUS.

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

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

**Anaprox DS 550 mg, #60:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 67.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS Page(s): p. 67-73.

**Decision rationale:** The injured worker has diagnoses of chronic back, neck, knee, and ankle pain. Per the MTUS, nonsteroidal anti-inflammatory drugs (NSAIDs) are recommended as a second line treatment after acetaminophen for treatment of acute exacerbations of chronic back pain. NSAIDs are noted to have adverse effects including gastrointestinal side effects and increased cardiovascular risk; besides these well-documented side effects of NSAIDs, NSAIDs have been shown to possibly delay and hamper healing in all the soft tissues including muscles, ligaments, tendons, and cartilage. They are recommended at the lowest dose for the shortest possible period in patients with moderate to severe pain. The documentation from the physician notes diagnoses of medication induced gastritis and gastrointestinal upset due to use of anaprox. Anaprox has been prescribed for at least 6-12 months and the quantity requested does not support short term use. There was no documentation of functional improvement as defined by MTUS as a result of use of anaprox. No specific result of use of this medication was discussed; the injured worker has remained off work and office visits have continued on an approximately

monthly basis, which does not support decreased dependence on medical care. For these reasons, the request for anaprox DS 550 mg #60 is not medically necessary.

**Prilosec 20 mg, #60:** Upheld

**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 risk Page(s): 66-68.

**Decision rationale:** The injured worker was taking anaprox, a nonsteroidal anti-inflammatory agent (NSAID) and the documentation from the physician notes a diagnosis of medication induced-gastritis. It was noted that the injured worker had gastrointestinal distress while taking norco in conjunction with anaprox and required Prilosec for this; physician documentation also notes that Prilosec is being utilized for gastrointestinal protection due to the injured worker's risk factors. Per the MTUS, risk factors for gastrointestinal (GI) events include age > 65 years, history of peptic ulcer, GI bleeding or perforation, concurrent use of aspirin, corticosteroids and/or an anticoagulant, or high dose/multiple NSAIDs; the injured worker does not have documentation of these risk factors. Long-term proton pump inhibitor use (greater than one year) has been shown to increase the risk for hip fracture. The documentation shows that this injured worker has been taking Prilosec from at least November 2012 to February 2014. In addition, the current request for anaprox has been determined to be not medically necessary. Due to the potential for toxicity, lack of GI risk factors, and lack of medical necessity for continued NSAID use, the request for Prilosec 20 mg #60 is not medically necessary.

**Ultram ER 150 mg, #30:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines tramadol p. 93-94, medications for chronic pain p. 60, opioids p. 74-96 Page(s): 93-94, 60, 74-9.

**Decision rationale:** Tramadol is a centrally acting synthetic opioid analgesic which is not recommended as a first line oral analgesic. The injured worker is also prescribed Lexapro, a SSRI. Multiple side effects of tramadol have been reported including increased risk of seizure especially in patients taking selective serotonin reuptake inhibitors (SSRIs), tricyclic antidepressants (TCAs) and other opioids. It may also produce life-threatening serotonin syndrome. The MTUS notes that patients taking tramadol with SNRI and SSRI antidepressants are at risk for life-threatening serotonin syndrome. There is no mention of discussion of this in the treating physician reports. The injured worker has also been prescribed norco and has been taking this medication for an extended period of time without documentation of functional improvement. The MTUS recommends that only one medication for chronic pain should be given at a time. Ultram ER 150 mg #30 is not medically necessary based on lack of benefit from opioids to date and potential for toxicity.

**Norco 10/325 mg, #240:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 78.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines p. 74-96.

**Decision rationale:** There is no evidence that the treating physician is prescribing opioids according to the MTUS, which recommends prescribing according to function, with specific functional goals, and return to work. There should be a prior failure of non-opioid therapy. None of these aspects of prescribing are in evidence. The injured worker has not returned to work and was documented to be not working since 1996. Per the MTUS, opioids are minimally indicated, if at all, for chronic non-specific pain, osteoarthritis, "mechanical and compressive etiologies", and chronic back pain. There is no evidence of significant pain relief or increased function from the opioids used to date. The prescribing physician does not specifically address function with respect to prescribing opioids. There is no evidence that the treating physician has utilized a treatment plan NOT using opioids, and that the patient "has failed a trial of non-opioid analgesics". Hydrocodone has a maximum recommended dose of 60 mg/24 hours; the documentation indicates the injured worker had been taking up to 8 tablets daily, which would exceed the recommended maximum dose. Ongoing management should reflect four domains of monitoring, including analgesia, activities of daily living, adverse side effects, and aberrant drug-taking behaviors. Discussion of adverse side effects, use of an opioid contract, and screening for aberrant drug-taking behaviors with urine drug screens were documented; however, the documentation does not reflect improvement in pain or change in specific activities of daily living as a result of use of norco. The injured worker has been treated with Norco for at least one year, with no documentation of functional improvement as a result of this medication, as defined by MTUS. Work status remains unchanged and office visits have continued at the same frequency of approximately monthly over the prior 6 months. For these reasons, the request for Norco 10/325 #240 is not medically necessary.