

<b>Case Number:</b>	CM15-0113998		
<b>Date Assigned:</b>	06/18/2015	<b>Date of Injury:</b>	08/01/2012
<b>Decision Date:</b>	07/21/2015	<b>UR Denial Date:</b>	05/27/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/12/2015

### 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, Pain Management

### 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 51 year old female patient who sustained an industrial injury on 08/01/2012. The accident was described as while sweeping a floor mat at work she ended up doing the splits and landing on the floor onto her left hip. She immediately felt crackling in the groin and reported injury to employer. She went home that day and was unable to return to work that following day and has not returned to work. She did receive medications, a cane, radiography testing, MRI scan and even a course of physical therapy. A primary visit dated 06/24/2014 reported the patient with subjective complaint of having shooting pain down her legs left side worse along with left groin pain. The pain is noted so intense at time she is unable to move. Nerve conduction studies have been with negative findings. A magnetic resonance imaging study revealed two level disc disease. The patient has access to a transcutaneous nerve stimulator unit, back brace and hot/cold wrap. She had received injection in September 2013 which greatly improved the situation. Of note, psychiatry had been approved but she has not gone. She even underwent a course of chiropractic therapy. Treating diagnoses are as follows: discogenic lumbar condition with facet inflammation and left sided radiculopathy; left hip strain/sprain with MRI showing minimal osteoarthritis and mild gluteus minimus tendinopathy status post injection with significant improvement; bilateral groin strain/sprain, overall recovered; internal derangement of bilateral knees, for which clarification of coverage is requested; element of depression, quite a bit improved; anxiety; insomnia; gastritis; sexual dysfunction; and weight gain of 50 pounds for which a referral to psychiatry is requested; urinary incontinence, overall significantly improved, vaginal discomfort with bulge with surgical

intervention 09/2000, 2002, and 2004. The plan of care involved the patient undergoing bilateral knee fluoroscopy, prescribed medications: Naproxen, Tramadol ER, Protonix, Terocin patches, LidoPro cream, Flexeril/Norflex. The patient was deemed permanent and stationary on 07/11/20014. The impression showed the patient with: discogenic lumbar condition with radicular component on left and positive MRI findings from L4-5 to L5-S1; nerve studies lower extremities unremarkable; hip joint inflammation with MRI showing arthritis of left hip; intermittent groin inflammation with MRI showing partial thickness tear of gluteus; patellar inflammation bilaterally; element of depression, anxiety, insomnia, diarrhea, and weight gain. There is standing recommendation to administer an injection once authorized. The patient is still with subjective complaint of low back with constant pain and intermittent spasms. The pain radiates into the left lower extremity with left sided cramping at the calf. In addition she has complaint of sleep issues. The patient is referred for a psychiatric consultation.

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

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

**Naproxen 55 mg Qty 60: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs (non-steroidal anti-inflammatory drugs).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): 67-72.

**Decision rationale:** Regarding the request for Naproxen, Chronic Pain Medical Treatment Guidelines state that NSAIDs are recommended at the lowest dose for the shortest period in patients with moderate to severe pain. Within the documentation available for review, there is no indication that Naproxen is providing any specific analgesic benefits (in terms of percent pain reduction, or reduction in numeric rating scale), or any objective functional improvement. The justification for this medication includes long citations of guidelines but lack specificity with respect to this patient. Given this, the currently requested Naproxen is not medically necessary.

**Protonix 20 mg Qty 60: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms and cardiovascular risk.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines PPI Page(s): 68-69.

**Decision rationale:** In this request, there is controversy over whether a PPI is warranted in this worker's treatment regimen. The Chronic Pain Medical Treatment Guidelines on page 68-69 states the following regarding the usage of proton pump inhibitors (PPI): Clinicians should weight the indications for NSAIDs against both GI and cardiovascular risk factors. 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). In the case of this injured worker, there is no documentation of any of the risk factors above including age, history of multiple NSAID use, history of gastrointestinal ulcer or bleeding, or use of concomitant anticoagulants or corticosteroids. Given this, this request is not medically necessary.

**Tramadol ER (extended release) 150 mg Qty 30:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Tramadol (Ultram).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Tramadol, Opioid Page(s): 75-80, 94.

**Decision rationale:** Tramadol is a centrally acting opioid agonist and also inhibits the reuptake of serotonin and norepinephrine. On July 2, 2014, the DEA published in the Federal Register the final rule placing tramadol into schedule IV of the Controlled Substances Act. This rule will become effective on August 18, 2014. The CPMTG specifies that this is a second line agent for neuropathic pain. Given its opioid agonist activity, it is subject to the opioid criteria specified on pages 76-80 of the CPMTG. With regard to this request, the California Chronic Pain Medical Treatment Guidelines state the following about on-going management with opioids: "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 for documentation of the clinical use of these controlled drugs." Guidelines further recommend discontinuing opioids if there is no documentation of improvement in function and reduction in pain. In the progress reports available for review, the primary treating physician did not adequately document monitoring of the four domains. Improvement in function was not clearly outlined. This can include a reduction in work restrictions or significant gain in some aspect of the patient's activities. Based on the lack of documentation, medical necessity of this request cannot be established at this time. Although this opioid is not medically necessary at this time, it should not be abruptly halted, and the requesting provider should start a weaning schedule as he or she sees fit or supply the requisite monitoring documentation to continue this medication. The request is not medically necessary.