

Case Number:	CM15-0126715		
Date Assigned:	07/13/2015	Date of Injury:	03/13/2007
Decision Date:	09/22/2015	UR Denial Date:	06/08/2015
Priority:	Standard	Application Received:	06/30/2015

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

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 59 year old male who sustained an industrial injury on 03/13/2007. The injured worker was diagnosed with lumbar disc displacement without myelopathy and right knee pain. The injured worker is status post right total knee arthroplasty in 2007, scar tissue removal in the right knee in 2008 and infection and debridement of the right knee in 2009. There were no surgical interventions to the lumbar spine documented. Treatment to date has included diagnostic testing with Dexa Scan of the hip and spine on April 2, 2015 and medications. There were no other treatments or therapies documented. According to the primary treating physician's progress report on April 16, 2015, the injured worker continues to experience severe low back pain and right knee pain. The injured worker is status post a cerebral vascular accident in 1994 with current contracture of the left arm and dysfunction of the left leg. The injured worker had a five beat clonus at the left patella reflex and hyperreflexia with normal deep tendon reflexes on the right side. Left Achilles reflex was not elicited. Motor function was difficult to assess secondary to overcompensation and weakness on the left side. The injured worker appeared to have no sensory dysfunction of the lower extremities on L3 through S1 dermatomal distribution. There was tenderness over the lumbar paraspinal and lumbar spine region. Current medications are listed as Buprenorphine HCL sublingual, Nabumetone, Seroquel and topical creams. Treatment plan consists of serum testosterone blood draw, possible lumbar epidural steroid injection and the current request for Nabumetone-Relafen, Pantoprazole, Quetiapine Fumarate-Seroquel, Buprenorphine HCL sublingual and Diclofenac Sodium.

IMR ISSUES, DECISIONS AND RATIONALES

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

Nabumetone-Relafen 500mg #90: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-inflammatory medications Page(s): 22.

Decision rationale: The patient presents on 06/11/15 with unrated lower back pain and unrated knee pain. The patient's date of injury is 03/13/07. Patient is status post right total knee replacement in 2007 with subsequent infection and debridement surgery in 2009. The request is for NABUMETONE-RELAFEN 500MG #90. The RFA is dated 06/11/15. Physical examination dated 06/11/15 notes that the patient ambulates with a cane and possesses an antalgic gait. No other abnormal physical findings are noted. The patient is currently prescribed Nabumetone, Pantoprazole, Buprenorphine, Seroquel, and Diclofenac. Diagnostic imaging included MRI of the lumbar spine dated 01/10/14, significant findings include: "Acute anterior wedge compression fracture of the L2 vertebral body with edema and approximately 50% vertebral body loss, L4-5 grade 1 degenerative anteriorlisthesis, 3mm disc bulge with a high intensity zone/annular fissure and facet hypertrophy with mild bilateral neural narrowing, possible right L5 pars interarticularis fracture." Patient is currently classified as permanent and stationary. MTUS Chronic Pain Medical Treatment Guidelines, pg 22 for Anti-inflammatory medications states: "Anti-inflammatories are the traditional first line of treatment, to reduce pain so activity and functional restoration can resume, but long-term use may not be warranted. A comprehensive review of clinical trials on the efficacy and safety of drugs for the treatment of low back pain concludes that available evidence supports the effectiveness of non-selective nonsteroidal anti-inflammatory drugs (NSAIDs) in chronic LBP and of antidepressants in chronic LBP." MTUS pg 60 under Medications for chronic pain also states, "A record of pain and function with the medication should be recorded," when medications are used for chronic pain. In regard to the continuation of Ibuprofen for this patient's chronic pain, adequate documentation of pain reduction and functional improvement has been provided. Progress note dated 6/11/15 documents analgesia and non-specific functional improvements attributed to medications, though does not specifically mention Relafen. Given the conservative nature of this medication and documented analgesia attributed to medications, continued use is substantiated. The request is medically necessary.

Pantoprazole-Protonix 20mg #60: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Chapter-updated 4/30/15.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms and cardiovascular risk Page(s): 69.

Decision rationale: The patient presents on 06/11/15 with unrated lower back pain and unrated knee pain. The patient's date of injury is 03/13/07. Patient is status post right total knee replacement in 2007 with subsequent infection and debridement surgery in 2009. The request is for pantoprazole-protonix 20mg #60. The RFA is dated 06/11/15. Physical examination dated 06/11/15 notes that the patient ambulates with a cane and possesses an antalgic gait. No other abnormal physical findings are noted. The patient is currently prescribed Nabumetone, Pantoprazole, Buprenorphine, Seroquel, and Diclofenac. Diagnostic imaging included MRI of the lumbar spine dated 01/10/14, significant findings include: "Acute anterior wedge compression fracture of the L2 vertebral body with edema and approximately 50% vertebral body loss, L4-5 grade 1 degenerative anteriorlisthesis, 3mm disc bulge with a high intensity zone/annular fissure and facet hypertrophy with mild bilateral neural narrowing, possible right L5 pars interarticularis fracture." Patient is currently classified as permanent and stationary. MTUS pg 69 states "NSAIDs, GI symptoms and cardiovascular risk: Treatment of dyspepsia secondary to NSAID therapy: Stop the NSAID, switch to a different NSAID, or consider H2-receptor antagonists or a PPI." Regarding Protonix, or a proton pump inhibitor, MTUS allows it for prophylactic use along with oral NSAIDs when appropriate GI risk is present such as age greater 65; concurrent use of anticoagulants, ASA or high dose of NSAIDs; history of PUD, gastritis, etc. This medication also can be used for GI issues such as GERD, PUD or gastritis. In regard to the continuation of Protonix, the request is appropriate. Progress note dated 06/11/15 notes that this patient has a history of gastroesophageal reflux disease and GI upset secondary to NSAID medications and that these symptoms are well controlled with the current medication regimen. Given this patient's history of GERD and current medication regimen, a PPI such as Protonix is an appropriate prophylactic measure. The request is medically necessary.

Quetiapine Fumarate-Seroquel 25mg #60: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Mental illness chapter under Atypical antipsychotics.

Decision rationale: The patient presents on 06/11/15 with unrated lower back pain and unrated knee pain. The patient's date of injury is 03/13/07. Patient is status post right total knee replacement in 2007 with subsequent infection and debridement surgery in 2009. The request is for quetiapine fumarate-seroquel 25mg #60. The RFA is dated 06/11/15. Physical examination dated 06/11/15 notes that the patient ambulates with a cane and possesses an antalgic gait. No other abnormal physical findings are noted. The patient is currently prescribed Nabumetone, Pantoprazole, Buprenorphine, Seroquel, and Diclofenac. Diagnostic imaging included MRI of the lumbar spine dated 01/10/14, significant findings include: "Acute anterior wedge compression fracture of the L2 vertebral body with edema and approximately 50% vertebral body loss, L4-5 grade 1 degenerative anteriorlisthesis, 3mm disc bulge with a high intensity zone/annular fissure and facet hypertrophy with mild bilateral neural narrowing, possible right L5 pars interarticularis fracture." Patient is currently classified as permanent and stationary.

Regarding atypical antipsychotics, ODG mental illness chapter states there is insufficient evidence to recommend-olanzapine, quetiapine, risperidone, ziprasidone, aripiperazole-for the treatment of PTSD. ODG does not recommend them as a first-line treatment. "Adding an atypical antipsychotic to an antidepressant provides limited improvement in depressive symptoms in adults, new research suggests. The meta-analysis also shows that the benefits of antipsychotics in terms of quality of life and improved functioning are small to nonexistent, and there is abundant evidence of potential treatment-related harm. The authors said that it is not certain that these drugs have a favorable benefit-to-risk profile. Clinicians should be very careful in using these medications. The American Psychiatric Association, APA, has released a list of specific uses of common antipsychotic medications that are potentially unnecessary and sometimes harmful. Antipsychotic drugs should not be first-line treatment to treat behavioral problems." In regard to the request for Seroquel, the treater has not substantiated that such a medication is appropriate for further use. This patient has been prescribed Seroquel since at least 04/16/15 for difficulty sleeping. Official disability guidelines indicate that such medications offer few benefits and uncertain benefit-to-risk profiles and do not recommend that Seroquel be used as a first-line treatment for behavioral problems such as insomnia. Owing to a lack of guideline support for conditions of this nature, and without a statement as to why such a medication is required for this patient, continuation cannot be substantiated. Therefore, this request is not medically necessary.

Diclofenac Sodium 1.5% 60grm #1: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111.

Decision rationale: The patient presents on 06/11/15 with unrated lower back pain and unrated knee pain. The patient's date of injury is 03/13/07. Patient is status post right total knee replacement in 2007 with subsequent infection and debridement surgery in 2009. The request is for DICLOFENAC SODIUM 1.5% 60GM #1. The RFA is dated 06/11/15. Physical examination dated 06/11/15 notes that the patient ambulates with a cane and possesses an antalgic gait. No other abnormal physical findings are noted. The patient is currently prescribed Nabumetone, Pantoprazole, Buprenorphine, Seroquel, and Diclofenac. Diagnostic imaging included MRI of the lumbar spine dated 01/10/14, significant findings include: "Acute anterior wedge compression fracture of the L2 vertebral body with edema and approximately 50% vertebral body loss, L4-5 grade 1 degenerative anteriorlisthesis, 3mm disc bulge with a high intensity zone/annular fissure and facet hypertrophy with mild bilateral neural narrowing, possible right L5 pars interarticularis fracture." Patient is currently classified as permanent and stationary. The MTUS has the following regarding topical creams (p111, chronic pain section): "Topical Analgesics: Recommended as an option as indicated below. Non-steroidal anti-inflammatory agents (NSAIDs): The efficacy in clinical trials for this treatment modality has been inconsistent and most studies are small and of short duration. Topical NSAIDs have been shown in meta- analysis to be superior to placebo during the first 2 weeks of treatment for osteoarthritis, but either not afterward, or with a diminishing effect over another 2-week period,

Voltaren Gel 1% (diclofenac): Indicated for relief of osteoarthritis pain in joints that lend themselves to topical treatment (ankle, elbow, foot, hand, knee, and wrist). It has not been evaluated for treatment of the spine, hip or shoulder." MTUS Chronic Pain Medical Treatment Guidelines, pg 9 under Pain Outcomes and Endpoints states: "All therapies are focused on the goal of functional restoration rather than merely the elimination of pain and assessment of treatment efficacy is accomplished by reporting functional improvement." In regard to the continuation of a topical formation containing Diclofenac, such topical creams are not indicated for this patient's chief complaint. This patient presents with the chief complaint of lower back pain. While the patient does have a history of right knee replacement with complications, and continuing pain in the joint, it is not clear from the records provided whether the cream is being applied on the spine or the knee. Progress notes only state "apply to affected area." It is noted that this patient receives analgesia and functional benefits from his medications. However, without evidence that this topical cream is being utilized for this patient's knee complaint, or a clear and appropriate statement as to where it is to be applied, continuation cannot be substantiated. The request is not medically necessary.

Buprenorphine HCL Sublingual 2mg #180: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids for chronic pain.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Medications for chronic pain, criteria for use of opioids Page(s): 60, 61, 76-78, 88, 89. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter under Buprenorphine.

Decision rationale: The patient presents on 06/11/15 with unrated lower back pain and unrated knee pain. The patient's date of injury is 03/13/07. Patient is status post right total knee replacement in 2007 with subsequent infection and debridement surgery in 2009. The request is for buprenorphine hcl sublingual 2MG #180. The RFA is dated 06/11/15. Physical examination dated 06/11/15 notes that the patient ambulates with a cane and possesses an antalgic gait. No other abnormal physical findings are noted. The patient is currently prescribed Nabumetone, Pantoprazole, Buprenorphine, Seroquel, and Diclofenac. Diagnostic imaging included MRI of the lumbar spine dated 01/10/14, significant findings include: "Acute anterior wedge compression fracture of the L2 vertebral body with edema and approximately 50% vertebral body loss, L4-5 grade 1 degenerative anteriorlisthesis, 3mm disc bulge with a high intensity zone/annular fissure and facet hypertrophy with mild bilateral neural narrowing, possible right L5 pars interarticularis fracture." Patient is currently classified as permanent and stationary. MTUS Guidelines pages 88 and 89 states, "Pain should be assessed at each visit, and functioning should be measured at 6-month intervals using a numerical scale or validated instrument." MTUS page 78 also requires documentation of the 4A's (analgesia, ADLs, adverse side effects, and adverse behavior), as well as "pain assessment" or outcome measures that include current pain, average pain, least pain, intensity of pain after taking the opioid, time it takes for medication to work and duration of pain relief. ODG-TWC, Pain Chapter states: "Buprenorphine for chronic pain: Recommended as an option for treatment of chronic pain in selected patients, not first-line for all patients. Suggested populations: 1. Patients with a

hyperalgesic component to pain; 2. Patients with centrally mediated pain; 3. Patients with neuropathic pain; 4. Patients at high-risk of non-adherence with standard opioid maintenance; 5. For analgesia in patients who have previously been detoxified from other high-dose opioids. Use for pain with formulations other than Butrans is off-label. Due to complexity of induction and treatment the drug should be reserved for use by clinicians with experience." In regard to the continuation of sublingual Buprenorphine, the treater has not provided adequate documentation of medication efficacy. Addressing the efficacy of this patient's medications, progress note dated 06/11/15 has the following statement: "He had analgesia, no aberrant drug behavior, no adverse effects from the medication. He does have improvement in his activities of daily living with the medication." Such vague statements do not satisfy MTUS guidelines, which require documentation of analgesia via a validated scale, activity-specific functional improvements, consistent urine drug screening, and a stated lack of aberrant behavior. In this case, the documentation includes evidence of a lack of aberrant behavior, and consistent urine drug screening (per toxicology report 06/11/15). However, there is no documentation of analgesia via a validated scale, nor specific functional improvements attributed to medications. Without such documentation, continuation of this medication cannot be substantiated. Owing to a lack of 4A's documentation, the request is not medically necessary.