Case Number:	CM15-0171013		
Date Assigned:	09/14/2015	Date of Injury:	06/07/2015
Decision Date:	10/13/2015	UR Denial Date:	08/12/2015
Priority:	Standard	Application Received:	08/31/2015

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: North Carolina
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 54 year old male with a date of injury of June 7, 2015. A review of the medical records indicates that the injured worker is undergoing treatment for shoulder impingement, medial epicondylitis, lumbar sprain and strain, and internal derangement of the knee not otherwise specified. Medical records dated July 15, 2015 indicate that the injured worker complains of a lot of pain in the left knee and toe. A progress note dated July 7, 2015 notes subjective complaints of occasional headache, constant stabbing pain in the bilateral shoulders rated at a level of 8 out of 10, tingling sensation in the bilateral shoulders, shoulder pain radiates to the arms, elbows, and hands, constant stabbing pain in the bilateral arms rated at a level of 7 out of 10 with tingling sensation and radiation to the elbows and hands, constant stabbing pain in the bilateral elbows rated at a level of 8 out of 10 that radiates to the hands, constant pain in the bilateral wrists and hands rated at a level of 6 to 7 out of 10, intermittent pain in the entire back rated at a level of 7 out of 10 at its worst and 6 out of 10 at its best, tingling sensation of the back, intermittent pain of the bilateral legs rated at a level of 7 out of 10, intermittent pain of the right knee rated at a level of 10 out of 10, swelling of the right knee, intermittent pain of the right ankle rated at a level of 7 out of 10, difficulty sleeping, and bouts of stress. The report also states that the injured worker has difficulties with activities of daily living such as sitting, climbing stairs, grasping, gripping, lifting and carrying heavy weight, pushing, pulling, bending, stooping, squatting, and reaching. Per the treating physician (July 7, 2015), the employee was on temporary total disability for six weeks. The physical exam dated July 15, 2015 reveals tenderness to pressure over the bilateral trapezius muscles, restricted range of motion of the bilateral shoulders,

positive impingement testing of the bilateral shoulders, tenderness to pressure over the bilateral medial elbows, positive Tinel's bilaterally, tenderness to palpation and spasm of the lumbar paraspinal muscles, restricted range of motion of the lumbar spine, positive straight leg raise bilaterally, tenderness to pressure over the bilateral knee joints, and positive McMurray's testing bilaterally. The progress note dated July 7, 2015 documented findings that were similar to that on July 15, 2015. Treatment has included medications (Ibuprofen 800mg once each day since at least July 7, 2015). The original utilization review (August 12, 2015) non-certified a request for Tramadol 50mg #60 and Carisoprodol 350mg #60, and partially certified a request for Naproxen Sodium 550mg #60 (original request for Naproxen Sodium 550mg #60 with two refills).

IMR ISSUES, DECISIONS AND RATIONALES

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

Carisoprodol 350mg 1 tablet BID #60: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guideline (ODG) Muscle relaxants (for pain).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Muscle relaxants (for pain).

Decision rationale: The California chronic pain medical treatment guidelines section on muscle relaxants states: Recommend non-sedating muscle relaxants with caution as a second-line option for short-term treatment of acute exacerbations in patients with chronic LBP. (Chou, 2007) (Mens, 2005) (Van Tulder, 1998) (van Tulder, 2003) (van Tulder, 2006) (Schnitzer, 2004) (See, 2008) Muscle relaxants may be effective in reducing pain and muscle tension, and increasing mobility. However, in most LBP cases, they show no benefit beyond NSAIDs in pain and overall improvement. Also there is no additional benefit shown in combination with NSAIDs. Efficacy appears to diminish over time, and prolonged use of some medications in this class may lead to dependence. (Homik, 2004) (Chou, 2004) This medication is not intended for long-term use per the California MTUS. The medication has not been prescribed for the flare-up of chronic low back pain. This is not an approved use for the medication. For these reasons, criteria for the use of this medication have not been met. Therefore the request is not medically necessary.

Tramadol HCL 50mg 1 tablet BID #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) Pain.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids for chronic pain.

Decision rationale: The California chronic pain medical treatment guidelines section on opioids states for ongoing management: On-Going Management. Actions Should Include: (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. Pain assessment should include: current pain; the least reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid; how long it takes for pain relief; and how long pain relief lasts. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. Information from family members or other caregivers should be considered in determining the patient's response to treatment. The 4 A's for Ongoing Monitoring: 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. (Passik, 2000) (d) Home: To aid in pain and functioning assessment, the patient should be requested to keep a pain dairy that includes entries such as pain triggers, and incidence of end-of-dose pain. It should be emphasized that using this diary will help in tailoring the opioid dose. This should not be a requirement for pain management. (e) Use of drug screening or inpatient treatment with issues of abuse, addiction, or poor pain control. (f) Documentation of misuse of medications (doctor-shopping, uncontrolled drug escalation, drug diversion). (g) Continuing review of overall situation with regard to non-opioid means of pain control. (h) Consideration of a consultation with a multidisciplinary pain clinic if doses of opioids are required beyond what is usually required for the condition or pain does not improve on opioids in 3 months. Consider a psych consult if there is evidence of depression, anxiety or irritability. Consider an addiction medicine consult if there is evidence of substance misuse. When to Continue Opioids (a) If the patient has returned to work; (b) If the patient has improved functioning and pain. (Washington, 2002) (Colorado, 2002) (Ontario, 2000) (VA/DoD, 2003) (Maddox-AAPM/APS, 1997) (Wisconsin, 2004) (Warfield, 2004) The long-term use of this medication class is not recommended per the California MTUS unless there documented evidence of benefit with measurable outcome measures and improvement in function. There is no documented significant improvement in VAS scores for significant periods of time. There are no objective measurements of improvement in function. Therefore all criteria for the ongoing use of opioids have not been met and the request is not medically necessary.

Naproxen Sodium 550mg 1 tablet BID # 60 with 2 refills: Overturned

Claims Administrator guideline: Decision based on MTUS Shoulder Complaints 2004, and Elbow Complaints 2007, and Low Back Complaints 2004.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): NSAIDs (non-steroidal anti-inflammatory drugs).

Decision rationale: NSAID therapy states: Recommended at the lowest dose for the shortest period in patients with moderate to severe pain. Acetaminophen may be considered for initial therapy for patients with mild to moderate pain, and in particular, for those with gastrointestinal,

cardiovascular or renovascular risk factors. NSAIDs appear to be superior to acetaminophen, particularly for patients with moderate to severe pain. There is no evidence to recommend one drug in this class over another based on efficacy. In particular, there appears to be no difference between traditional NSAIDs and COX-2 NSAIDs in terms of pain relief. The main concern of selection is based on adverse effects. COX-2 NSAIDs have fewer GI side effects at the risk of increased cardiovascular side effects, although the FDA has concluded that long-term clinical trials are best interpreted to suggest that cardiovascular risk occurs with all NSAIDs and is a class effect (with naproxyn being the safest drug). There is no evidence of long-term effectiveness for pain or function. (Chen, 2008) (Laine, 2008) Back Pain: Chronic low back pain: Recommended as an option for short-term symptomatic relief. A Cochrane review of the literature on drug relief for low back pain (LBP) suggested that NSAIDs were no more effective than other drugs such as acetaminophen, narcotic analgesics, and muscle relaxants. The review also found that NSAIDs had more adverse effects than placebo and acetaminophen but fewer effects than muscle relaxants and narcotic analgesics. In addition, evidence from the review suggested that no one NSAID, including COX-2 inhibitors, was clearly more effective than another. (Roelofs-Cochrane, 2008) See also Anti-inflammatory medications. Neuropathic pain: There is inconsistent evidence for the use of these medications to treat long term neuropathic pain, but they may be useful to treat breakthrough and mixed pain conditions such as osteoarthritis (and other nociceptive pain) in with neuropathic pain. This medication is recommended for the shortest period of time and at the lowest dose possible. The dosing of this medication is within the California MTUS guideline recommendations. The definition of shortest period possible is not clearly defined in the California MTUS. Therefore the request is medically necessary.