

<b>Case Number:</b>	CM15-0176136		
<b>Date Assigned:</b>	09/25/2015	<b>Date of Injury:</b>	06/07/2011
<b>Decision Date:</b>	11/25/2015	<b>UR Denial Date:</b>	08/10/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/08/2015

### 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: Oregon  
 Certification(s)/Specialty: Plastic Surgery, Hand Surgery

### 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 31 year old male injured worker suffered an industrial injury on 6-7-2011. The diagnoses included left wrist sprain with possible scapholunate disassociation and possible early Kienbocks disease. On 7-31-2015 the provider reported he had access to hot and cold wraps and 2 lead TENS unit and the Norco use had increased to 60 tablets a month. On exam, there was left wrist tenderness. On 8-7-2015, the treating provider reported his wrist pain was slowly getting worse with less wrist motion with issues of "sleep, GI irritation and depression". A description of the cause of the GI irritation was not included. On exam the provider noted there was synovitis in the left wrist and diffuse tenderness with reduced range of motion. The documentation provided did not include evidence of a comprehensive pain evaluation with pain levels with and without medications, with and without TENS unit therapy, no evidence of functional improvement with treatment and no aberrant risk assessment. Prior treatment included 2 wrist injections, tensynovectomy and physical therapy. Diagnostics included MR arthrogram. Request for Authorization date was 7-31-2015. The Utilization Review on 8-10-2015 determined non-certification for Naproxen 550mg #60, Protonix 20mg #60, Neurontin 600mg #90, Tramadol ER 150mg #30, Norco #60, Four lead TENS unit with conductive garment, and Urine drug screen 10-panel.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Naproxen 550mg #60: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

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

**Decision rationale:** Per MTUS page 67, NSAIDS: "Osteoarthritis (including knee and hip): 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." "Back Pain - Acute exacerbations of chronic pain: Recommended as a second-line treatment after acetaminophen." "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." MTUS supports a short course of NSAIDS. The patient has been on both Norco and NSAIDS without objective pain improvement. MTUS supports only a short course of therapy with NSAIDS. Additional NSAIDS are not warranted. Therefore, the request is not medically necessary.

**Protonix 20mg #60: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

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

**Decision rationale:** MTUS regarding the use of proton pump inhibitors (PPI) such as protonix, for prophylaxis use indicates that the following risk factors should be present, "(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)." Documentation provided does not suggest that the patient has any of the noted risk factors noted above and the omeprazole is recommended non-certified. The patient does not have a history of anti-coagulation, previous reaction to NSAIDS or peptic ulcer disease. The records only document previous GI upset of indeterminate etiology. The guidelines do not support routine use of PPI's for patients taking NSAIDS. Therefore, the request is not medically necessary.

**Neurontin 600mg #90: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Antiepilepsy drugs (AEDs).

**Decision rationale:** Per MTUS page 16: Anti-epilepsy drugs (AEDs) are also referred to as anti-convulsants: Recommended for neuropathic pain (pain due to nerve damage). Per MTUS page 18: Gabapentin (Neurontin, Gabarone™, generic available) has been shown to be effective for treatment of diabetic painful neuropathy and post herpetic neuralgia and has been considered as a first-line treatment for neuropathic pain. For lumbar spinal stenosis: Recommended as a trial, with statistically significant improvement found in walking distance, pain with movement, and sensory deficit found in a pilot study. (Yaksi, 2007) This patient does not have neuropathic pain. He has pain from Keinbock's disease with associated arthritis. MTUS does not support gabapentin for arthritis pain. Therefore, the request is not medically necessary.

**Tramadol ER 150mg #30:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** Decision based on MTUS General Approaches 2004, Section(s): Initial Approaches to Treatment.

**Decision rationale:** Per ACOEM, Initial Approaches to Treatment, page 47 and 48, OPIOIDS: Opioids appear to be no more effective than safer analgesics for managing most musculoskeletal and eye symptoms; they should be used only if needed for severe pain and only for a short time. Opioids cause significant side effects, which the clinician should describe to the patient before prescribing them. Poor patient tolerance, constipation, drowsiness, clouded judgment, memory loss, and potential misuse or dependence have been reported in up to 35% of patients. Patients should be informed of these potential side effects. Per MTUS page 113: Tramadol (Ultram) - Tramadol (Ultram) is a centrally acting synthetic opioid analgesic and it is not recommended as a first-line oral analgesic. The patient has been on Norco. ACOEM does not support chronic use of opiates and specifically does not recommend Norco as a first line treatment. The request is not medically necessary and should not be certified.

**Norco #60:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** Decision based on MTUS General Approaches 2004, Section(s): Initial Approaches to Treatment.

**Decision rationale:** Per ACOEM, Initial Approaches to Treatment, page 47 and 48, OPIOIDS: Opioids appear to be no more effective than safer analgesics for managing most musculoskeletal and eye symptoms; they should be used only if needed for severe pain and only for a short time. Opioids cause significant side effects, which the clinician should describe to the patient before prescribing them. Poor patient tolerance, constipation, drowsiness, clouded judgment, memory loss, and potential misuse or dependence have been reported in up to 35% of patients. Patients should be informed of these potential side effects. This patient has been on chronic opiates. ACOEM does not support long-term use of opiates. Other pain management interventions are preferred due to the addictive nature of opiates and the risk of hyperalgesia. Therefore, the request is not medically necessary.

**Four lead TENS unit with conductive garment:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Transcutaneous electrotherapy.

**Decision rationale:** Rental. Per the MTUS guidelines, "Transcutaneous electrotherapy", page 114, TENS is Not recommended as a primary treatment modality, but a one-month home-based TENS trial may be considered as a noninvasive conservative option, if used as an adjunct to a program of evidence-based functional restoration, for the conditions described below. Recommendations by types of pain: A home-based treatment trial of one month may be appropriate for neuropathic pain and CRPS II (conditions that have limited published evidence for the use of TENS as noted below), and for CRPS I (with basically no literature to support use). Neuropathic pain: Some evidence (Chong, 2003), including diabetic neuropathy (Spruce, 2002) and post-herpetic neuralgia. (Niv, 2005) Phantom limb pain and CRPS II: Some evidence to support use. (Finsen, 1988) (Lundeberg, 1985) Spasticity: TENS may be a supplement to medical treatment in the management of spasticity in spinal cord injury. (Aydin, 2005) Multiple sclerosis (MS): While TENS does not appear to be effective in reducing spasticity in MS patients it may be useful in treating MS patients with pain and muscle spasm. (Miller, 2007) This patient does not have neuropathic pain, spasticity or CRPS. He has pain from Keinbocks. This should be relieved with surgery. He has had a trial of TENS without objective improvement. TENS is not required. Therefore, the request is not medically necessary.

**Urine drug screen 10-panel:** Overturned

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Chapter, Urine drug testing (UDT).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids, steps to avoid misuse/addiction.

**Decision rationale:** This patient has a diagnosis of chronic pain. The American College of Occupational and Environmental Medicine (ACOEM) in the Occupational Medicine Practice Guidelines on Chronic Pain supports urine drug screens. It is stated on page 156:

Recommendation: Urine Drug Screening for Patients Prescribed Opioids for Chronic Pain.

Routine use of urine drug screening for patients on chronic opioids is recommended, as there is evidence that urine drug screens can identify aberrant opioid use and other substance use that otherwise is not apparent to the treating physician. Indications - All patients on chronic opioids for chronic pain. This patient is on chronic opioids. He has been on Norco for a period of time, and additional narcotics are being requested. His pain is likely to persist. ACOEM supports urine drug screen in this setting. Therefore, the request is medically necessary.