

<b>Case Number:</b>	CM15-0072726		
<b>Date Assigned:</b>	04/23/2015	<b>Date of Injury:</b>	10/24/2013
<b>Decision Date:</b>	06/11/2015	<b>UR Denial Date:</b>	03/31/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/16/2015

### 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: 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 45 year old female who sustained an industrial injury on October 24, 2013. The injured worker was diagnosed as having discogenic cervical condition with facet inflammation, headaches, and shoulder girdle involvement, disc disease at C2-C3, C4-C5, and C5-C6, ulnar neuritis bilaterally, carpal tunnel syndrome bilaterally, wrist joint inflammation bilaterally with carpometacarpal (CMC) joint inflammation bilaterally, impingement of shoulder with rotator cuff strain, biceps tendinitis, acromioclavicular joint inflammation bilaterally, depression, insomnia, stress, and anxiety related to orthopedic condition, and chronic pain syndrome. Medical history included hypertension. Evaluation has included MRI scan of the cervical spine and electrodiagnostic studies. Treatment to date has included physical therapy, bracing, transcutaneous electrical nerve stimulation (TENS), neck traction, hot and cold wrap, and medication. Progress notes from the primary treating physician from October 2014 to March 2015 were submitted, as was a Qualified Medical Examination from 3/16/15 which included summary of prior evaluation and treatment. The documentation indicates that the injured worker last worked in December 2013. Current work status was noted as retired. Nonsteroidals and muscle relaxants were noted to be prescribed in November of 2013. Flexeril and gabapentin were prescribed in March of 2014. Naproxen was prescribed in April of 2014, Vicodin was prescribed in September of 2014, and nalfon was prescribed in January of 2015. Medications in October 2014 included Vicodin, gabapentin, flexeril, Neurontin, protonix, and naproxen. Currently, the injured worker complains of numbness in her arms and spasms along her neck. It was noted that the injured worker minimized chores and sometimes had difficulty with personal

hygiene. Marginally controlled hypertension was noted. Gastrointestinal (GI) irritation was noted. The treating physician's report dated March 10, 2015, noted a MRI of the cervical spine showed eccentric disc disease at C2-C3 to the left, protrusion to the left at C5-C6 and C6-C7, and bulging at C4-C5. Blood pressure was 145/96. Physical examination was noted to show a positive Tinel's at the elbows, especially on the right, with hyperflexion test positive on the left side. Tenderness along the carpal tunnel area was noted bilaterally, with facet tenderness bilaterally. It was noted that blood testing for liver and kidney function was being done through the injured worker's primary care physician. The treatment plan included requests for authorization for a hinged elbow brace, a ten panel urine drug screen (UDS), physical therapy for the neck and upper extremities, medications including Fenoprofen Calcium, Venlafaxine, Trazadone, Orphenadrine, Topiramate, Eszopiclone, LidoPro, Norco, Valium, Colace, and Gabapentin, and a fluoroscopic evaluation of the left elbow and left wrist. On 3/31/15, Utilization Review non-certified or modified requests for the medications currently under Independent Medical Review, citing the MTUS and ODG.

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

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

**Naproxen 550 mg #60 (Anaprox) NSAID:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs (non-steroidal anti-inflammatory drugs) Page(s): 67-68.

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

**Decision rationale:** This injured worker has chronic neck and arm pain. Non-steroidals have been prescribed for at least six months and possibly more than one year. 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. The MTUS does not specifically reference the use of NSAIDs for long term treatment of chronic pain in other specific body parts. There was no documentation of functional improvement as a result of NSAIDS. The documentation indicates that the injured worker has not worked since December 2013 and limitations of activities of daily living were noted, with no report of improvement. 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. GI irritation was noted without documentation of evaluation or consideration of contribution of NSAIDs. NSAIDs can increase blood pressure and may cause fluid retention, edema, and congestive heart failure; all NSAIDS are relatively contraindicated in patients with renal insufficiency, congestive heart failure, or volume excess. They are recommended at the lowest dose for the shortest possible period in patients with moderate to severe pain. Systemic toxicity is possible with NSAIDs. The FDA and MTUS recommend monitoring of blood tests and blood pressure. This injured worker has a history of hypertension which was documented to be marginally controlled, with elevated blood pressure reading at the most recent office visit; this was not addressed. Blood tests were noted to be done through the

injured worker's primary care physician, but dates and results of testing were not provided or discussed. The current requests also include a request for another oral NSAID, fenoprofen, which is duplicative and potentially toxic. Due to length of use of NSAIDS in excess of the guidelines, lack of functional improvement and potential for toxicity, the request for naproxen is not medically necessary.

**Gabapentin 600 mg #90 (Neurontin) anticonvulsant: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Antiepilepsy drugs (AEDs) Page(s): 16-18.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines anticonvulsants (antiepilepsy drugs (AEDs)) Page(s): 16-22.

**Decision rationale:** This injured worker has chronic neck and arm pain, with documentation of carpal tunnel syndrome. Per the MTUS, antiepilepsy drugs (AEDs) are recommended for neuropathic pain due to nerve damage. Gabapentin has been shown to be effective for treatment of diabetic neuropathy and postherpetic neuralgia and has been considered a first line treatment for neuropathic pain. A "good" response to the use of AEDs is defined as a 50% reduction in pain and a "moderate" response as a 30% reduction. Lack of at least a 30% response per the MTUS would warrant a switch to a different first line agent or combination therapy. After initiation of treatment, there should be documentation of pain relief with improvement in function, and documentation of any side effects, with continued use of AEDs dependent on improved outcomes versus tolerability of adverse effects. The injured worker has been prescribed gabapentin for at least six months and possibly for as long as one year. There was no documentation of reduction in pain or improvement in function as a result of use of Gabapentin. The documentation indicates that the injured worker has not worked since December 2013 and limitations of activities of daily living were noted, with no report of improvement. There was no documentation of decrease in medication use, or decrease in frequency of office visits. Antiepileptic drugs (AEDs) are associated with teratogenicity and should be used with caution in women of childbearing age. There is no evidence that the treating physician has discussed this with this reproductive age female; there was no evidence for informed consent to use a reproductive hazard. Due to lack of documentation of improvement in pain or function, as well as potential for teratogenicity, the request for Gabapentin is not medically necessary.

**Lidopro ointment 121 gm #1 bottle topical pain: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-112.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines topical analgesics Page(s): 111-113.

**Decision rationale:** This injured worker has chronic neck and arm pain, as well as carpal tunnel syndrome. The site of application of lidopro ointment and directions for use were not provided. Per the MTUS, topical analgesics are recommended for neuropathic pain when trials of

antidepressants and anticonvulsants have failed. Lidocaine is only FDA approved for treating post-herpetic neuralgia, and the dermal patch form (Lidoderm) is the only form indicated for neuropathic pain. No other commercially approved topical formulations of lidocaine (whether creams, lotions, or gels) are indicated for neuropathic pain. Non-dermal patch forms are generally indicated as local anesthetics or anti-pruritics. This injured worker does not have a diagnosis of post-herpetic neuralgia. There was no discussion of failure of antidepressants. As this form of lidocaine is not recommended by the guidelines, the request for Lidopro ointment 121 gm #1 bottle topical pain is not medically necessary.

**Orphenadrine 100 mg #60 (Norflex) muscle relaxer:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain) Page(s): 63-65.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines muscle relaxants Page(s): 63-66.

**Decision rationale:** The MTUS for chronic pain does not recommend muscle relaxants for chronic pain. Non-sedating muscle relaxants are an option for short-term exacerbations of chronic low back pain. The muscle relaxant prescribed in this case is sedating. The injured worker has chronic pain with no evidence of prescribing for flare-ups. The quantity prescribed implies long term use, not for a short period of use for acute pain. This injured worker has been prescribed muscle relaxants (flexeril) for at least 6 months and possibly for more than one year. No reports show any specific and significant improvement in pain or function as a result of prescribing muscle relaxants. The reason for prescription of orphenadrine was not noted by the treating physician. Orphenadrine (Norflex) is similar to diphenhydramine, but with greater anticholinergic effects; the mode of action is not clearly understood and effects are thought to be secondary to analgesic and anticholinergic properties. Side effects include drowsiness, urinary retention, and dry mouth; it has been reported in case studies to be abused for euphoria and to have mood elevating effects. Due to length of use of muscle relaxants in excess of the guidelines without documentation of functional improvement, the request for orphenadrine is not medically necessary.

**Topiramate 50 mg (Topamax) #60 antioconvulsant:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Antiepilepsy drugs (AEDs) Page(s): 16-21.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines anticonvulsants (antiepilepsy drugs (AEDs)) Page(s): 16-22.

**Decision rationale:** This injured worker has chronic neck and arm pain, with documentation of carpal tunnel syndrome. Per the MTUS, anti-epilepsy drugs (AEDs) are recommended for neuropathic pain due to nerve damage. Topamax has been shown to have variable efficacy, with failure to demonstrate efficacy in neuropathic pain of "central" etiology. It is still considered for use for neuropathic pain when other anticonvulsants fail. This injured worker has been

prescribed gabapentin, without documentation of functional improvement, but trial and failure of any other anticonvulsants was not documented and the treating physician has continued to prescribe gabapentin. Antiepileptic drugs (AEDs) are associated with teratogenicity and should be used with caution in women of childbearing age. There is no evidence that the treating physician has discussed this with this reproductive age female; there was no evidence for informed consent to use a reproductive hazard. Due to lack of documentation of failure of other anticonvulsants, and due to potential for teratogenicity, the request for topamax is not medically necessary.

**Fenoprofen Calcium 400 mg #60 NSAID: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk Page(s): 68-69.

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

**Decision rationale:** This injured worker has chronic neck and arm pain. Non-steroidals have been prescribed for at least six months and possibly more than one year. Per the MTUS, non-steroidal anti-inflammatory drugs (NSAIDs) are recommended as a second line treatment after acetaminophen for treatment of acute exacerbations of chronic back pain. The MTUS does not specifically reference the use of NSAIDs for long term treatment of chronic pain in other specific body parts. There was no documentation of functional improvement as a result of NSAIDS. The documentation indicates that the injured worker has not worked since December 2013 and limitations of activities of daily living were noted, with no report of improvement. 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. GI irritation was noted without documentation of evaluation or consideration of contribution of NSAIDs. NSAIDs can increase blood pressure and may cause fluid retention, edema, and congestive heart failure; all NSAIDS are relatively contraindicated in patients with renal insufficiency, congestive heart failure, or volume excess. They are recommended at the lowest dose for the shortest possible period in patients with moderate to severe pain. Systemic toxicity is possible with NSAIDs. The FDA and MTUS recommend monitoring of blood tests and blood pressure. This injured worker has a history of hypertension which was documented to be marginally controlled, with elevated blood pressure reading at the most recent office visit; this was not addressed. Blood tests were noted to be done through the injured worker's primary care physician, but dates and results of testing were not provided or discussed. The current requests also include a request for another oral NSAID, naproxen, which is duplicative and potentially toxic. Due to length of use of NSAIDS in excess of the guidelines, lack of functional improvement, and potential for toxicity, the request for Fenoprofen is not medically necessary.

**Norco (Hydrocodone/APAP) 10/325 mg #60 narcotic: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 78, 124.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines opioids Page(s): 74-96.

**Decision rationale:** This injured worker has chronic neck and arm pain. Hydrocodone/acetaminophen has been prescribed for at least 6 months. There is insufficient evidence that the treating physician is prescribing opioids according to the MTUS, which recommends prescribing according to function, with specific functional goals, return to work, random drug testing, and opioid contract. None of these aspects of prescribing are in evidence. 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 documentation indicates that the injured worker has not worked since December 2013 and limitations of activities of daily living were noted, with no report of improvement. There was no documentation of decrease in medication use, or decrease in frequency of office visits. Ongoing management should reflect four domains of monitoring, including analgesia, activities of daily living, adverse side effects, and aberrant drug-taking behaviors. The documentation does not reflect improvement in pain. Change in activities of daily living, discussion of adverse side effects, and screening for aberrant drug-taking behaviors were not documented. The MTUS recommends urine drug screens for patients with poor pain control and to help manage patients at risk of abuse. There is no record of a urine drug screen program performed according to quality criteria in the MTUS and other guidelines. As currently prescribed, Norco does not meet the criteria for long term opioids as elaborated in the MTUS and is therefore not medically necessary.

**Colace 20 mg #60 stool softener:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines: Pain chapter - Opioid induced constipation treatment.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Initiating Therapy [with opioids] Page(s): 77. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) chronic pain chapter: opioid induced constipation treatment.

**Decision rationale:** The MTUS notes that when initiating therapy with opioids, prophylactic treatment of constipation should be initiated. Per the ODG, constipation occurs commonly in patients receiving opioids. If prescribing opioids has been determined to be appropriate, prophylactic treatment of constipation should be initiated. First line treatment includes increasing physical activity, maintaining appropriate hydration, and diet rich in fiber. Some laxatives may help to stimulate gastric motility, and other medications can help loosen otherwise hard stools, add bulk, and increase water content of the stool. Although laxatives are indicated when opioids are prescribed, the opioids are not medically necessary in this case. The treating physician has not provided other reasons for laxatives so laxatives would not be medically necessary if opioids are not prescribed. As such, the request for Colace is not medically necessary.