

<b>Case Number:</b>	CM15-0099715		
<b>Date Assigned:</b>	06/02/2015	<b>Date of Injury:</b>	07/25/2007
<b>Decision Date:</b>	06/30/2015	<b>UR Denial Date:</b>	04/28/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/25/2015

### 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: New Jersey, Alabama, California  
 Certification(s)/Specialty: Neurology, Neuromuscular 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 35 year old female who sustained an industrial slip and fall injury on 07/25/2007. The injured worker was diagnosed with lumbar post-laminectomy syndrome, cauda equina syndrome, neurogenic bladder and bowel and radial styloid tenosynovitis. The injured worker has successfully completed a functional restoration program (FRP). Treatments include physical therapy, acupuncture therapy, home exercise program and medications. Surgery documentation included lumbar back surgery and right tendon release for De Quervain's (no dates documented). According to the primary treating physician's progress report on April 20, 2015, the injured worker continues to experience chronic low back pain. Examination of the lumbar spine demonstrated decreased range of motion in all planes with bilateral paravertebral muscle tenderness, spasm and tight bands. The spinous process is tender on L4 and L5. Straight leg raise was positive on the right. The injured worker was unable to walk on toes or heels. Gait was normal without the use of assistive devices. Mild weakness of right knee flexion and right foot drop was noted. Patella and hamstring reflex were decreased bilaterally, absent Achilles reflex on the right side and 1/3 on the left side. Current medications are listed as Methadone, Cymbalta, Promethazine, Prevacid and Motrin. The injured worker remains Permanent & Stationary (P&S). Treatment plan consists of continuing with medication regimen and tapering of methadone, home exercise program, follow-up with urologist, and the current request for Methadone 5mg 2-3/day, Prevacid and Motrin.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Motrin 800mg quantity 120 with two refills:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Naproxen Page(s): 66.

**Decision rationale:** According to MTUS guidelines, Motrin is indicated for relief of pain related to osteoarthritis and back pain for the lowest dose and shortest period of time. There is no documentation that the shortest and the lowest dose of Motrin was used. There is no clear documentation of pain and functional improvement with NSAID use. Therefore, the prescription of Motrin 800mg #120 with 2 refills is not medically necessary.

**Methadone 5mg quantity 90:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for use of opioids Page(s): 76-79.

**Decision rationale:** According to MTUS guidelines, Methadone is "recommended as a second-line drug for moderate to severe pain if the potential benefit outweighs the risk. The FDA reports that they have received reports of severe morbidity and mortality with this medication. This appears, in part, secondary to the long half-life of the drug (8-59 hours). Pain relief on the other hand only lasts from 4-8 hours. Methadone should only be prescribed by providers experienced in using it." (Clinical Pharmacology, 2008). According to MTUS guidelines, ongoing use of opioids should follow specific rules: "(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." Methadone is a long acting opioid that should be used with caution when its benefit is superior to its risk. The

patient still complaining of moderate to severe back pain despite the use of several pain medications including opioids. There is no clear evidence of patient compliance with her medications. In addition, the provider has to document ongoing efficacy with prior use of opioids. Therefore, the request for Methadone 5mg #90 is not medically necessary

**Prevacid 30mg quantity 30 with two refills: Upheld**

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

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

**Decision rationale:** According to MTUS guidelines, Prevacid is indicated when NSAID are used in patients with intermediate or high risk for gastrointestinal events. The risk for gastrointestinal events are: (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). Recent studies tend to show that H. Pylori does not act synergistically with NSAIDS to develop gastroduodenal lesions. There is no documentation that the patient have GI issue that requires the use of Prevacid .There is no documentation in the patient's chart supporting that she is at intermediate or high risk for developing gastrointestinal events. Therefore, Prevacid prescription is not medically necessary.