

<b>Case Number:</b>	CM13-0015682		
<b>Date Assigned:</b>	10/10/2013	<b>Date of Injury:</b>	09/12/2005
<b>Decision Date:</b>	05/05/2014	<b>UR Denial Date:</b>	08/13/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/23/2013

### 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. The expert reviewer is Board Certified in Physical Medicine & Rehabilitation, has a subspecialty in Pain Medicine and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### 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 51-year-old male with a date of injury of September 12, 2005. The patient carries a diagnosis of lumbar disc displacement, chronic low back pain, lateral epicondylitis, and is status post surgery hernia repairs with groin pain. The patient is on Anaprox, Prilosec, Ultram, and Norco. The patient states that the medications are helpful. The patient has a compliant urine drug screen performed in May 2013 that was positive for the presence of hydrocodone. The disputed issues include a request for Prilosec, Norco, and tizanidine. A utilization review determination denied the Prilosec specifying that the submitted documentation's "do not objectively support the request for omeprazole at this time." There is "no documentation of gastrointestinal conditions or an increase risk to support the use of this medication." With regards the Norco, the reviewer felt there was no objective benefit to the claimant from this medication. "His level of pain relief has not been described. Functional improvement as a result of its use has not been described." With regard to the tizanidine, the claimant has chronic pain but "without significant spasms noted." Objective evidence of benefit to the claimant from this medication is unclear according to the utilization reviewer.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**PRILOSEC 20MG, ONE CAPSULE ONCE A DAY, #60 (THREE MONTH SUPPLY):**

Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS Page(s): 68-69.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines PPI AND NSAIDS SECTION Page(s): 68-69.

**Decision rationale:** "Clinicians should weight the indications for NSAIDs against both GI and cardiovascular risk factors. Determine if the patient is at risk for gastrointestinal events: (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. Recommendations Patients with no risk factor and no cardiovascular disease: Non-selective NSAIDs OK (e.g, ibuprofen, naproxen, etc.) Patients at intermediate risk for gastrointestinal events and no cardiovascular disease:(1) A non-selective NSAID with either a PPI (Proton Pump Inhibitor, for example, 20 mg omeprazole daily) or misoprostol (200  $\hat{P}$ ¼g four times daily) or (2) a Cox-2 selective agent. Long-term PPI use (> 1 year) has been shown to increase the risk of hip fracture (adjusted odds ratio 1.44). Patients at high risk for gastrointestinal events with no cardiovascular disease: A Cox-2 selective agent plus a PPI if absolutely necessary. Patients at high risk of gastrointestinal events with cardiovascular disease: If GI risk is high the suggestion is for a low-dose Cox-2 plus low dose Aspirin (for cardioprotection) and a PPI. If cardiovascular risk is greater than GI risk the suggestion is naproxyn plus low-dose aspirin plus a PPI. (Laine, 2006) (Scholmerich, 2006) (Nielsen, 2006) (Chan, 2004) (Gold, 2007) (Laine, 2007)" Although this patient has chronic abdominal pain and a history of right inguinal hernia repair with Perry incisional pain, there is no documentation of any gastrointestinal risk factors such as peptic ulcer or a history of G.I. bleeding. The guidelines specify that patients on nonselective NSAID medications do not require proton pump inhibitors, which have been prescribed chronically for this patient since at least September 2012. Given the lack of documentation, this request is recommended for noncertification.

**ONE PRESCRIPTION OF NORCO 10/325MG, ONE TABLET EVERY FOUR TO SIX HOURS FOR SERVE PAIN #120:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines OPIOIDS Page(s): 74-95.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines OPIOID SECTION Page(s): 76-80.

**Decision rationale:** The Chronic Pain Medical Treatment Medical Guidelines on pages 76-80 state the following criteria for the ongoing use of opioids, including: "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 nonadherent) 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)" This injured worker has documentation of chronic pain and has been on narcotics since at least late 2012. Urine drug screens have been consistently performed including one specimen collected September 28, 2012. The final summary results specified that this was a consistent result, although the hydrocodone was not attracted even though a progress note on September 28, 2012 indicated that the patient is taking Norco every 4 to 6 hours as needed for moderate pain. There were subsequent consistent drug screens, however. The patient has a compliant urine drug screen performed in May 2013 that was positive for the presence of hydrocodone. This indicates appropriate monitoring for aberrant behavior. There are other requirements of opioid monitoring including monitoring for adverse effects and demonstration of functional benefit. In all the submitted progress notes, this is not documented. Rather the requesting healthcare provider states in these sections entitled discussions and recommendations that the provider has questioned the patient in regards to medications provide above and that the patient has stated the medications "have been of benefit." There should be other objectives documentation of functional benefit with more specificity such as a change in work status. This request is recommended for noncertification. Non-certification does not equate with abrupt cessation and the requesting healthcare provider should taper the medication as he or she sees appropriate or provide the requisite information for opioid monitoring as per the California Medical Treatment and Utilization Schedule

**ONE PRESCRIPTION OF ZANAFLEX 4MG, #120 (THREE MONTH SUPPLY):**  
Overturned

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines MUSCLE RELAXANTS Page(s): 63-65.

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

**Decision rationale:** The Chronic Pain Medical Treatment Medical Guidelines on page 66 states the following regarding tizanidine: "Tizanidine (Zanaflex®), generic available) is a centrally acting alpha2-adrenergic agonist that is FDA approved for management of spasticity; unlabeled use for low back pain. (Malanga, 2008) Eight studies have demonstrated efficacy for low back pain. (Chou, 2007) One study (conducted only in females) demonstrated a significant decrease in pain associated with chronic myofascial pain syndrome and the authors recommended its use as a first line option to treat myofascial pain. (Malanga, 2002) May also provide benefit as an adjunct treatment for fibromyalgia. (ICSI, 2007)" In the case of this injured worker, a significant source of pain is documented to be in the abdominal wall after having both right and left inguinal hernia repairs. The etiology of this abdominal wall pain is likely to be soft tissue and muscular and etiology. Tizanidine is recommended as a 2nd line medication appears to be used appropriately

as the patient is also taking anti-inflammatories and tramadol. This request is recommended for certification. It is noted to the requesting healthcare provider that there should be specific documentation of any adverse effects to this medication in future visits.