

<b>Case Number:</b>	CM13-0060833		
<b>Date Assigned:</b>	12/30/2013	<b>Date of Injury:</b>	11/18/2004
<b>Decision Date:</b>	04/04/2014	<b>UR Denial Date:</b>	11/18/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/04/2013

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Neurology has a subspecialty in Neuromuscular 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 physician 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:

This is a 42 year old male who has reported back pain after an injury on November 18 2004. He underwent lumbar fusion at L4-L5 and L5-S1. He has been diagnosed with postlaminectomy syndrome, mental illness, and radiculitis. He has been treated with injections, radiofrequency ablation, and long term medications. Medications have included Neurontin, Lyrica, Prilosec, Fexmid, Oxycontin, and Anaprox. His treating physician has been prescribing medications under Independent Medical Review for years. While being prescribed these medications, the treating physician has described the injured worker as "temporarily totally disabled". The reports over time continue to refer to a decreasing use of Oxycontin, although the medication list over the last few months does not appear to have any decreasing quantities. Fexmid was dispensed on 7/24/13, without a specific indication. Prilosec was stated to be for "gastritis-type symptoms", with no further explanation. Subsequent reports have the same statements. A urine drug screen on 3/27/13 was positive for Hydrocodone, Oxycodone, and Oxymorphone. The medication list from that and prior dates did not include Hydrocodone. This urine drug screen result was not discussed by the treating physician. The urine drug screen on 7/24/13 has an abnormal specific gravity, and was not discussed by the treating physician. On 11/18/13, Utilization Review certified OxyContin 20 mg #60 of #120, noting good pain relief with recent injections and lack of need for #120. Prilosec was not certified based on lack of indications and the California MTUS. Anaprox was non-certified due to chronic use not in accordance with the California MTUS. Fexmid was not certified based on chronic use not in accordance with the California MTUS.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Prilosec 20mg, #60:** Upheld

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

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

**Decision rationale:** There are no medical reports which adequately describe the relevant signs and symptoms of possible GI disease. There is no examination of the abdomen on record. There are many possible etiologies for GI symptoms; the available reports do not provide adequate consideration of these possibilities. Empiric treatment after minimal evaluation is not indicated. Cotherapy with an NSAID is not indicated in patients other than those at high risk. No reports describe the specific risk factors present in this case. The reference to "gastritis-like symptoms" is never adequately explained or evaluated. If one were to presume that a medication were to be the cause of the GI symptoms, the treating physician would be expected to change the medication regime accordingly, at least on a trial basis to help determine causation. Note the MTUS recommendation regarding the options for NSAID-induced dyspepsia. In this case, there is no evidence of any attempts to determine the cause of symptoms, including minimal attempts to adjust medications. The MTUS, FDA, and recent medical literature have described a significantly increased risk of hip, wrist, and spine fractures; pneumonia, Clostridium-difficile-associated diarrhea, and hypomagnesemia in patients on proton pump inhibitors (PPIs). Omeprazole is not medically necessary based on lack of medical necessity and risk of toxicity.

**Anaprox DS 550mg, #60:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Medications for chronic pain , NSAIDs for Back Pain - Acute exacerbations of chronic pain, Back. Decision based on Non-MTUS Citation MTUS: CHRONIC PAIN MEDICAL TREATMENT GUIDELINES , NON SELECTIVE NSAIDS, 72

**Decision rationale:** Per the MTUS for chronic pain, medications should be trialed one at a time, and there should be functional improvement with each medication. No reports show any specific benefit, functional or otherwise. References to functional benefit in the records are non-specific, and belied by the "temporarily totally disabled" work status. Systemic toxicity is possible with NSAIDs. The FDA and MTUS recommend monitoring of blood tests and blood pressure. There is no evidence that the prescribing physician is adequately monitoring for toxicity as recommended by the FDA and MTUS. The MTUS does not recommend chronic NSAIDs for low back pain; NSAIDs should be used for the short term only. Acetaminophen is the drug of choice for flare-ups, followed by a short course of NSAIDs. The treating physician has been dispensing NSAIDs for years, which is counter to the recommendations of the MTUS for

treatment of back pain. Anaprox is not medically necessary based on the MTUS recommendations against chronic use, lack of specific functional and symptomatic benefit, and prescription not in accordance with the MTUS and the FDA warnings.

**Fexmid 7.5mg, #120:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants Page(s): 63.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Cyclobenzaprine, muscle relaxants Page(s): 41, 63.

**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. This patient has chronic pain with no evidence of prescribing for flare-ups. No reports show any specific and significant improvements in pain or function as a result of prescribing muscle relaxants. Any references to functional improvement are countered by the ongoing "temporarily totally disabled" work status. Cyclobenzaprine, per the MTUS, is indicated for short term use only and is not recommended in combination with other agents. Per the MTUS, Fexmid is not indicated and is not medically necessary.

**OXYCONTING 20 MG #120:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74-97.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 75-81.

**Decision rationale:** MTUS Guidelines state that Oxycodone as well as other short acting opioids are indicated for intermittent or breakthrough pain (page 75). It can be used in acute post operative pain. It is not recommended for chronic pain of longterm use as prescribed in this case. In addition and 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. The patient responded to Oxycontin 2 tabs per day and there is no justification to use Oxycontin 4 tabs per day. Therefore, the prescription of OxyContin 20 MG #120 is not medically necessary at this time.