

Case Number:	CM13-0063066		
Date Assigned:	12/30/2013	Date of Injury:	11/20/2009
Decision Date:	09/16/2014	UR Denial Date:	11/26/2013
Priority:	Standard	Application Received:	12/09/2013

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 California, has a subspecialty in Family 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:

This is a 27 year old female who reported an industrial injury on 11/20/2009, almost 5 years ago, attributed to the performance of her customary job tasks. The patient complains of right hip and knee pain. The patient has been treated for right greater trochanteric bursitis due to abnormal gait; right knee internal derangement, and right pes anserine bursitis. The patient reported pain to the medial right knee. The objective findings on examination included TTP to the superior patella; inferior medial knee TTP over the pes anserine bursa. The patient was prescribed Ketorprofen; Omeprazole; Orphenadrine ER and Norco 5/325 mg.

IMR ISSUES, DECISIONS AND RATIONALES

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

KETOPROFEN 75 MG #60: 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 anti-inflammatory medications Page(s): 67-68. Decision based on Non-MTUS Citation chapter--medications for chronic pain and NSAIDs.

Decision rationale: The use of Ketorprofen for chronic hip and knee pain in a 27-year-old patient is consistent with the currently accepted guidelines and the general practice of medicine for

musculoskeletal strains and injuries; however, the reported injury is 5 years old in a young person. There is no demonstrated medical necessity for Ketoprofen over the available OTC analgesics. The prescription of Ketoprofen is not supported with objective evidence as there is no documented aggravation and there is no demonstrated inflammation. There are no objective findings documented other than TTP. There is no evidence that OTC NSAIDs or acetaminophen would not be sufficient for the treatment of the patient for the objective findings documented. There is no documented failure of OTC medications. The continued prescription of ketoprofen 75 mg #60 over the available OTC NSAIDs is not documented to be medically necessary.

OMEPRAZOLE DR 20 MG #30: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines anti-inflammatory medication Page(s): 67-68. Decision based on Non-MTUS Citation (ODG) pain chapter-medications for chronic pain; NSAIDs.

Decision rationale: The MTUS Chronic Pain Medical Treatment Guidelines section on anti-inflammatory medications and gastrointestinal symptoms states; "Determine if the patient is at risk for gastrointestinal events." The medical records provided for review do not provide additional details in regards to the above assessment needed for this request. No indication or rationale for gastrointestinal prophylaxis is documented in the records provided. There are no demonstrated or documented GI issues attributed to NSAIDs for this patient. The patient was prescribed Omeprazole routine for prophylaxis with Ketoprofen. The protection of the gastric lining from the chemical effects of NSAIDs is appropriately accomplished with the use of the proton pump inhibitors such as Omeprazole. The patient is not documented to be taking NSAIDs. There is no industrial indication for the use of Omeprazole due to "stomach issues" or stomach irritation. The proton pump inhibitors provide protection from medication side effects of dyspepsia or stomach discomfort brought on by NSAIDs. The use of Omeprazole is medically necessary if the patient were prescribed conventional NSAIDs and complained of GI issues associated with NSAIDs. Whereas 50% of patient taking NSAIDs may complain of GI upset, it is not clear that the patient was prescribed Omeprazole automatically. The prescribed opioid analgesic, not an NSAID, was accompanied by a prescription for Omeprazole without documentation of complications. There were no documented GI effects of the NSAIDs to the stomach of the patient and the Omeprazole was dispensed or prescribed routinely. There is no demonstrated medical necessity for the prescription for omeprazole 20 mg #30.

ORPHENADRINE ER 100 MG #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain) Page(s): 63-66.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment Page(s): 47, Chronic Pain Treatment Guidelines muscle relaxants for pain Page(s): 63-64.

Decision rationale: The prescription for Norflex (Orphenadrine ER) 100 mg is not demonstrated to be medically necessary in the treatment of the cited diagnoses. The chronic use of muscle relaxants is not recommended by the ACOEM Guidelines or the Official Disability Guidelines for the treatment of subacute neck and shoulder pain. The use of muscle relaxants are recommended to be prescribed only briefly for a short course of treatment for muscle spasms and there is no recommendation for chronic use. The patient was not documented to have muscle spasms to the hip or knee. The prescription for orphenadrine ER is not demonstrated to be medically necessary for the effects of the industrial injury 5 years ago. The California MTUS states that non-sedating muscle relaxants are to be used with caution as a second line option for short-term treatment of acute exacerbations in patients with chronic low back pain. Muscle relaxants may be effective in reducing pain and muscle tension and increasing mobility. However, in most low back pain cases there is no benefit beyond NSAIDs in pain and overall improvement. There is no additional benefit shown in combination with NSAIDs. Efficacy appears to be diminished over time and prolonged use of some medications in this class may lead dependence. There is no current clinical documentation regarding this medication. A prescription for a muscle relaxant no longer appears to be medically reasonable or medically necessary for this patient. Additionally, muscle relaxants are not recommended for long-term use.

HYDROCODONE (NORCO) 5/325 MG #60: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation NO GUIDELINES WERE CITED BY THE CLAIMS ADMINISTRATOR.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74-97. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2ndEdition, (2004) Chapter 6 pages 114-116; chapter 12 pages 300-306.

Decision rationale: The provider has not establish functional improvement as a result of the current regimen of Norco 5/325 mg #60 directed to reported right hip and knee pain 5 years after the DOI. As noted by evidence-based guidelines, opiates may be continued if the patient has returned to work and has improved functioning and pain. Additionally, there is no indication of an improvement in pain levels or functionality to substantiate ongoing utilization of opiate medication. Long-term use of opiates is not supported by current evidence based guidelines. ODG states: "Routine long-term opioid therapy is not recommended, and ODG recommends consideration of a one-month limit on opioids for new chronic non-malignant pain patients in most cases, as there is little research to support its use." The patient has been taking opiate medication on a long-term basis, which is not consistent with evidence-based guidelines. The prescription for Norco 5/325 mg #60 for short acting pain is being prescribed as an opioid analgesic for the treatment of chronic pain to the knee and hip for the date of injury 5 years ago. The objective findings on examination do not support the clinical diagnoses. The patient is being prescribed opioids for chronic knee and hip pain documented as TTP which is inconsistent with the recommendations of the California MTUS. There is no objective evidence provided to support the continued prescription of opioid analgesics for the cited diagnoses and effects of the

industrial claim. The patient should be titrated down and off the prescribed Norco. The chronic use of Norco is not recommended by the California MTUS; the ACOEM Guidelines or the Official Disability Guidelines for the long term treatment of chronic pain. The prescription of opiates on a continued long-term basis is inconsistent with the California MTUS and the Official Disability Guidelines recommendations for the use of opiate medications for the treatment of chronic pain. There is objective evidence that supports the use of opioid analgesics in the treatment of this patient over the use of NSAIDs for the treatment of chronic pain. The current prescription of opioid analgesics is inconsistent with evidence based guidelines. The prescription of opiates on a continued long-term basis is inconsistent with the Official Disability Guidelines recommendations for the use of opiate medications for the treatment of chronic pain. There is objective evidence that supports the use of opioid analgesics in the treatment of this patient over the use of NSAIDs for the treatment of chronic pain issues. Evidence based guidelines necessitate documentation that the patient has signed an appropriate pain contract, functional expectations have been agreed to by the clinician and the patient, pain medications will be provided by one physician only, and the patient agrees to use only those medications recommended or agreed to by the clinician to support the medical necessity of treatment with opioids. The ACOEM Guidelines updated chapter on chronic pain states "Opiates for the treatment of mechanical and compressive etiologies: rarely beneficial. Chronic pain can have a mixed physiologic etiology of both neuropathic and nociceptive components. In most cases, analgesic treatment should begin with acetaminophen, aspirin, and NSAIDs (as suggested by the WHO step-wise algorithm). When these drugs do not satisfactorily reduce pain, opioids for moderate to moderately severe pain may be added to (not substituted for) the less efficacious drugs. A major concern about the use of opioids for chronic pain is that most randomized controlled trials have been limited to a short-term period. This leads to a concern about confounding issues such as tolerance, opioid-induced hyperalgesia, long-range adverse effects such as hypogonadism and/or opioid abuse, and the influence of placebo as a variable for treatment effect. ACOEM guidelines state that 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. The long-term use of opioid medications may be considered in the treatment of chronic musculoskeletal pain, if: The patient has signed an appropriate pain contract; Functional expectations have been agreed to by the clinician and the patient; Pain medications will be provided by one physician only; The patient agrees to use only those medications recommended or agreed to by the clinician. ACOEM also notes, "Pain medications are typically not useful in the subacute and chronic phases and have been shown to be the most important factor impeding recovery of function. Evidence based guidelines recommend: Chronic back pain: Appears to be efficacious but limited for short-term pain relief, and long-term efficacy is unclear (>16 weeks), but also appears limited. Failure to respond to a time-limited course of opioids has led to the suggestion of reassessment and consideration of alternative therapy. There is no evidence to recommend one opioid over another. In patients taking opioids for back pain, the prevalence of lifetime substance use disorders has ranged from 36% to 56% (a statistic limited by poor study design). Limited information indicated that up to one-fourth of patients who receive opioids exhibit aberrant medication-taking behavior. The ODG states that chronic pain can have a mixed physiologic etiology of both neuropathic and nociceptive components. In most cases, analgesic treatment should begin with acetaminophen, aspirin, and NSAIDs (as suggested by the WHO step-wise algorithm). When these drugs do not satisfactorily reduce pain, opioids for moderate to moderately severe pain may be added to (not

substituted for) the less efficacious drugs. A major concern about the use of opioids for chronic pain is that most randomized controlled trials have been limited to a short-term period. This leads to a concern about confounding issues such as tolerance, opioid-induced hyperalgesia, long-range adverse effects such as hypogonadism and/or opioid abuse, and the influence of placebo as a variable for treatment effect. (Ballantyne, 2006) (Furlan, 2006) Long-term, observational studies have found that treatment with opioids tends to provide improvement in function and minimal risk of addiction, but many of these studies include a high dropout rate (56% in a 2004 meta-analysis). (Kalso, 2004) There is also no evidence that opioids showed long-term benefit or improvement in function when used as treatment for chronic back pain. (Martell-Annals, 2007) (ODG, Pain Chapter). There is no clinical documentation by the requesting provider with objective findings on examination to support the medical necessity of Norco for this long period of time 5 years s/p DOI. There is no provided evidence that the patient has received benefit or demonstrated functional improvement with the prescribed Norco. There is no demonstrated medical necessity for the prescribed Opioids over the readily available OTC analgesics. The patient should have been weaned down and discontinued from the prescribed hydrocodone by this time.