

Case Number:	CM14-0113405		
Date Assigned:	08/01/2014	Date of Injury:	05/15/2000
Decision Date:	09/10/2014	UR Denial Date:	06/27/2014
Priority:	Standard	Application Received:	07/21/2014

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 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 60 year old male patient who reported an industrial injury on 5/15/2000, over 14 years ago, attributed to the performance of his job tasks when he was reportedly struck by a vehicle. The patient reports neck and back pain. The patient has undergone surgical intervention to the cervical spine and lumbar spine. The patient is diagnosed with post lumbar laminectomy syndrome, post cervical laminectomy syndrome, spinal/lumbar degenerative disc disease; and low back pain. The patient currently complains of lower back pain radiating down to the right lower extremity. The patient reported weakness to his right foot and ankle, which reportedly caused him to fall. The medications prescribed included lactulose, Prilosec, Celebrex, Senna cot, Roxycodone, morphine sulfate, Colace, Rozerme, Lexapro, Lyrica, and Ativan. The objective findings on examination included; appears in moderate pain; antalgic gait; assisted by cane; surgical scars of the lumbar spine; diminished range of motion to the lumbar spine; spasm tenderness and tight muscles with sugar points to the lumbar spine. The treatment plan included discontinuing Celebrex and starting a trial of Duexis 800/26.6 mg #60; Norco 10/Sen. 25 mg #120; morphine sulfate 15 mg #120; oxycodone 30 mg #270.

IMR ISSUES, DECISIONS AND RATIONALES

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

Trial Duexis 800/26.6mg #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines ANTI-INFLAMMATORY MEDICATIONS Page(s): 22, 67-68. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) pain chapter-medications for chronic pain; NSAIDs.

Decision rationale: The provider has prescribed Duexis 800/26.6 #60 mg which is a combination of Ibuprofen and Famotidine (Pepcid) both of which are available OTC. There is no demonstrated medical necessity for this compounded medication. There is no objective evidence that the patient cannot be treated fully with OTC analgesics. The use of ibuprofen by the patient was minimal and no GI effects were documented. There is no medical necessity for this prescribed Duexis over the use of OTC Ibuprofen and Pepcid. Famotidine is an antihistamine H2 blocker is prescribed for GERD or stomach discomfort when NSAIDs are being prescribed; however there is no objective evidence that the H2 inhibitor is as effective at protecting the mucosal layer of the stomach as the recommended proton pump inhibitors. Generally, the proton pump inhibitors are prescribed to protect the stomach lining from the chemical effects of NSAIDs. There are prescribed NSAIDs in the current medical documentation; however, there is no objective evidence provided that the prescribed NSAIDs have caused GI upset due to the erosion of the GI mucosa. The protection of the stomach lining from NSAIDs is appropriately provided with the proton pump inhibitors such as Omeprazole. There are no documented GI issues with the prescribed Ibuprofen and the H2 blocker is prescribed prophylactically. There is no demonstrated medical necessity for Duexis 800/26.6 mg bid #60.

Norco 10/325mg #120: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300-306, Chronic Pain Treatment Guidelines OPIOIDS Page(s): 74-97. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) chapter 6 pages 114-116 OFFICIAL DISABILITY GUIDELINES (ODG) PAIN CHAPTER-OPIOIDS.

Decision rationale: The prescription for Hydrocodone-APAP (Norco) 10/325 mg #120 for short acting pain is being prescribed as an opioid analgesic for the treatment of chronic pain to the back for the date of injury over 14 years ago. The objective findings on examination do not support the medical necessity for continued opioid analgesics. The patient is being prescribed opioids for mechanical back/neck pain which is inconsistent with the recommendations of the CA 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 of the prescribed Hydrocodone. The patient is 14 years s/p DOI with reported continued issues. There is no demonstrated medical necessity for the continuation of opioids for the effects of the industrial injury. The chronic use of Hydrocodone-APAP/Norco is not recommended by the CA MTUS; the ACOEM Guidelines or the Official Disability Guidelines for the long term treatment of chronic back pain. The prescription of opiates on a

continued long term basis is inconsistent with the CA MTUS and the Official Disability Guideline 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 Guideline 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 (70 days). 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 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 that "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." There is no clinical documentation by with objective findings on examination to support the medical necessity of Hydrocodone-APAP for this long period of time or to support ongoing functional improvement. There is no provided evidence that the patient has received benefit or demonstrated functional improvement with the prescribed Hydrocodone-APAP. There is no demonstrated medical necessity for the prescribed Opioids. The continued prescription for Norco 10/325 mg #120 is not demonstrated to be medically necessary.

Morphine Sulfate 15mg #120: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300-306, Chronic Pain Treatment Guidelines OPIOIDS Page(s): 74-97. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine

Decision rationale: The prescription for Morphine Sulfate 15 mg #120 for short acting pain is being prescribed as an opioid analgesic for the treatment of chronic pain to the back/neck for the date of injury 14 years ago. The objective findings on examination do not support the medical necessity for continued opioid analgesics. The patient is being prescribed opioids for mechanical back/neck pain which is inconsistent with the recommendations of the CA 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 of the prescribed Morphine Sulfate. The patient is 14 years s/p DOI with reported continued issues. There is no demonstrated medical necessity for the continuation of opioids for the effects of the industrial injury. The chronic use of Morphine Sulfate 15 mg #120 is not recommended by the CA MTUS; the ACOEM Guidelines or the Official Disability Guidelines for the long term treatment of chronic back pain. The prescription of opiates on a continued long term basis is inconsistent with the CA 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 (70 days). 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 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 that "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." There is no clinical

documentation by with objective findings on examination to support the medical necessity of Morphine Sulfate 15 mg #120 for this long period of time or to support ongoing functional improvement. There is no provided evidence that the patient has received benefit or demonstrated functional improvement with the prescribed Morphine Sulfate. There is no demonstrated medical necessity for the prescribed Opioids. The continued prescription for Morphine Sulfate 15 mg #120 is not demonstrated to be medically necessary.

Roxicodone 30mg #120: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300-306, Chronic Pain Treatment Guidelines OPIOIDS Page(s): 74-97. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) chapter 6 pages 114-116 OFFICIAL DISABILITY GUIDELINES (ODG) PAIN CHAPTER-OPIOIDS.

Decision rationale: The prescription for Roxicodone 30 mg #120 for short acting pain is being prescribed as an opioid analgesic for the treatment of chronic pain to the back/neck for the date of injury 14 years ago. The objective findings on examination do not support the medical necessity for continued opioid analgesics. The patient is being prescribed opioids for mechanical back/neck pain which is inconsistent with the recommendations of the CA 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 of the prescribed Roxicodone 30 mg #120. The patient is 14 years s/p DOI with reported continued issues. There is no demonstrated medical necessity for the continuation of opioids for the effects of the industrial injury. The chronic use of Roxicodone 30 mg #120 is not recommended by the CA MTUS; the ACOEM Guidelines or the Official Disability Guidelines for the long term treatment of chronic back pain. The prescription of opiates on a continued long term basis is inconsistent with the CA 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 (70 days). 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 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 that "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." There is no clinical documentation by with objective findings on examination to support the medical necessity of Hydrocodone-APAP for this long period of time or to support ongoing functional improvement. There is no provided evidence that the patient has received benefit or demonstrated functional improvement with the prescribed Hydrocodone-APAP. There is no demonstrated medical necessity for the prescribed Opioids. The continued prescription for Roxycodone 30 mg #120 is not demonstrated to be medically necessary.