MAXIMUS Federal Services

Case Number:	CM14-0116151		
Date Assigned:	08/04/2014	Date of Injury:	10/23/2012
Decision Date:	09/10/2014	UR Denial Date:	07/08/2014
Priority:	Standard	Application Received:	07/23/2014

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 North Carolina. 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 patient is a 43-year-old with a reported date of injury of 10/23/2012 that occurred while lifting and carrying an air-conditioning unit. The patient has the diagnoses of lumbar spondylosis, foraminal stenosis and right sciatica. Per the progress note provided by the treating physician dated 05/14/2014, the patient had complaints of right sided low back pain radiating down the right leg to the knee. Physical exam noted positive straight leg raise test on the right, restriction in range of motion of the lumbar spine and intact neurologic examination. Treatment recommendations included consideration of physical therapy, chiropractic care, additional injection and medications. Per progress notes from another treating physician dated 07/28/2014, the patient had an admission for suicidal ideation. Physical exam noted positive straight leg raise test on the left and intact neurologic examination. Treatment recommendations included psychology visits, acupuncture, decrease Norco to once a day and continuation of Celebrex.

IMR ISSUES, DECISIONS AND RATIONALES

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

Celebrex 200mg tablet 1 tablet by mouth every day, #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs (non-steroidal anti-inflammatory drugs) Page(s): 30, 70.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs page(s) 68 Page(s): 68.

Decision rationale: The California chronic pain medical treatment guidelines section on NSAID uses states:Recommend with precautions as indicated below.Clinicians should weight the indications for NSAIDs against both GI and cardiovascular riskfactors.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.RecommendationsPatients 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 g 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.The patient has no documented cardiovascular or gastrointestinal risk factors to justify the use of Celebrex over a traditional NSAID and thus the request is not certified.

Norco 10/325mg tablet 1 tablet by mouth daily as needed for severe pain #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 91, 76-78, 78-80,124.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines opioids page(s) 74-88 Page(s): 74-88.

Decision rationale: The California chronic pain medical treatment guidelines section on opioid use states:On-Going Management. Actions Should Include:(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 nonadherent) drug-related behaviors. These domains have been summarized as the "4 A's" (analgesia, activities of daily living, adverse side effects, and aberrant drugtaking 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)(d) Home: To aid in pain and functioning assessment, the patient should be requested to keep a pain

dairy that includes entries such as pain triggers, and incidence of end-of-dosepain. It should be emphasized that using this diary will help in tailoring the opioid dose. This should not be a requirement for pain management.(e) Use of drug screening or inpatient treatment with issues of abuse, addiction, or poor pain control.(f) Documentation of misuse of medications (doctor-shopping, uncontrolled drugescalation, drug diversion).(g) Continuing review of overall situation with regard to nonopioid means of paincontrol.(h) Consideration of a consultation with a multidisciplinary pain clinic if doses of opioids are required beyond what is usually required for the condition or pain does not improve on opioids in 3 months. Consider a psych consult if there is evidence of depression, anxiety or irritability. Consider an addiction medicine consult if there is evidence of substance misuse.- 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 reassement and consideration of alternative therapy. There is no evidence to recommend one opioid over another.Outcomes measures: It is now suggested that rather than simply focus on pain severity, improvements in a wide range of outcomes should be evaluated, including measures of functioning, appropriate medication use, and side effects. Measures of pain assessment that allow for evaluation of the efficacy of opioids and whether their use should be maintained include the following: 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. (Nicholas, 2006) (Ballantyne, 2006) A recent epidemiologic study found that opioid treatment for chronic non-malignant pain did not seem to fulfill any of key outcome goals including pain relief, improved quality of life, and/or improved functional capacity. (Eriksen, 2006).The long-term use of opioids for back pain is not recommended. In addition there is no quantitative measure of outcomes with the medication in the provided documentation. For these reasons, the request is not certified.