

Case Number:	CM14-0129565		
Date Assigned:	08/20/2014	Date of Injury:	03/14/2011
Decision Date:	12/31/2014	UR Denial Date:	07/15/2014
Priority:	Standard	Application Received:	08/14/2014

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 46-year old woman has chronic neck, back, shoulder, hand and wrist pain as well as depression, anxiety and a sleep disorder, with a date of injury of 4/26/11. Physical symptoms apparently are attributed to motions performed during the normal course of work duties in an office, with subsequent psychological problems due to pain. Ongoing diagnoses include chronic cervicgia, reactive anxiety, depression, bilateral upper extremity neuropathic and radicular pain, carpal tunnel syndrome, myofascial pain and fibromyalgia. Although the patient's work status is documented as modified, she apparently has not worked for years. The available records contain multiple progress reports from both the patient's primary treater, a physiatrist, and from secondary treaters who are psychologists. The most recent note available from the primary treater is dated 3/24/14. The following information from a 6/26/14 progress note from the primary treater was obtained from a 7/14/14 UR report, since the note itself is not in the records. As of 6/26/14, the patient was taking Lunesta, Valium, Amrix, Celebrex and Lyrica, and using Lidoderm patches and topical Voltaren. Exam findings included painful limitation of neck and wrist motions, and diminished sensation in the right hand in a median nerve distribution. A trial of Duexis is recommended, as well as a continuation of Doxepin. Apparently no rationale is documented for the provision of Duexis. A 7/15/14 UR report documents certification of Doxepin and non-certification of Duexis.

IMR ISSUES, DECISIONS AND RATIONALES

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

Duexis 800 26.6 mg #60: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Medications for Chronic Pain; NSAIDs (non-steroidal anti-inflammatory drugs); NSAIDs, GI symptom. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain chapter, Duexis

Decision rationale: Duexis is a brand-name combination of two generically available drugs: ibuprofen and famotidine. Ibuprofen is an NSAID (non-steroidal anti-inflammatory drug) and famotidine is an H2 blocker used for peptic acid related disorders. Per the first reference cited above, medications should be trialed one at a time while other treatments are held constant, with careful assessment of function, and there should be functional improvement with each medication in order to continue it. The NSAID references state that NSAIDs are recommended at the lowest dose for the shortest period possible for patients with moderate to severe pain due to osteoarthritis. There is no evidence to recommend one drug over another in terms of efficacy or pain relief. Cardiovascular risk occurs with all NSAIDs, and there is no evidence of long-term effectiveness for pain or function. NSAIDs are recommended as an option for short-term symptomatic relief of chronic low back pain. There is inconsistent evidence to support their use for neuropathic pain. Clinicians should weight the indications for NSAIDs against both GI and cardiovascular risk factors. They should determine if the patient is at risk for GI events. Risk factors include age over 65 years; history of peptic ulcer, GI bleeding or perforation; concurrent use of aspirin, corticosteroids, or an anticoagulant; or high-dose or multiple NSAIDs, or an NSAID combined with aspirin. Patients with no GI risk factors and no cardiovascular disease may be prescribed a non-selective NSAID. Those at intermediate risk for GI disease should receive a non-selective NSAID plus a proton pump inhibitor (PPI) or misoprostol; or a Cox-2 selective NSAID. Patients at high GI risk should receive a Cox-2 selective NSAID and a PPI if an NSAID is absolutely necessary. According to the ODG citation above, Duexis is not recommended as a first-line drug. It was launched by [REDACTED] with the indications of rheumatoid and osteoarthritis. Ibuprofen and famotidine are available in multiple strengths over the counter, and other strategies are recommended to prevent stomach ulcers in patients taking NSAIDs, specifically proton pump inhibitors. Duexis is not recommended as first-line therapy because it has less benefit and higher cost than other available therapies. The clinical findings in this case do not support the use of Duexis for this patient. Although the specific NSAID prescribed periodically changes, this patient has been taking an NSAID for months to years, without any documented improvement in function. She has not returned to work. Given that no NSAID has been shown to provide better pain relief than any other, and that there is no documentation of an acute exacerbation of this patient's chronic pain, continued use of an NSAID is not appropriate. In addition, there is no documentation of this patient's risk for GI events. If this patient were at risk, the appropriate medication to combine with an NSAID would be a PPI, not an H2 blocker such as famotidine. Finally, the patient is not documented as having either rheumatoid or osteoarthritis, which are the only indications for Duexis use, and even if she were there are more effective and less expensive treatments available than Duexis. Based on the citations above and on the clinical information made available for my review, Duexis 800/26.6 mg #60 is not medically necessary. It is not medically necessary because long-term NSAID use

has not resulted in any functional recovery for this patient and changing to a new NSAID is not likely to do so, because there is no documentation of the patient's GI risk factors, because famotidine is unlikely to be the drug of choice for any documented GI risk factor, and because Duexis is not recommended by the ODG since there are more effective and cheaper alternative pharmacologic treatments available for any condition for which Duexis might be indicated. The request for Duexis 800 26.6 mg#60 is not medically necessary.