

Case Number:	CM14-0130499		
Date Assigned:	09/08/2014	Date of Injury:	10/23/2012
Decision Date:	10/30/2014	UR Denial Date:	07/30/2014
Priority:	Standard	Application Received:	08/15/2014

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 37-year old man reported a low back injury due to lifting at work 10/23/14. Treatment to date has included medications, physical therapy, pool therapy, an epidural steroid injection, acupuncture, and TENS. He was judged not to be a surgical candidate. The available records contain an AME report that refers to notes from visits with the current primary treater dated 3/13/13 to 12/17/13. The 12/17/13 note lists the patient's current medications as including Norco, Relafen, and Flexeril. It is unclear how long he had been taking these medications. There are five notes from the primary treater's office, all signed by mid-level providers, ranging in date from 1/12/14 through 7/7/14. The first three of these notes document that the patient is taking Relafen. These notes are signed by two different PAs. On 4/17/14 there is a note from a nurse practitioner which states that the patient does not really think Relafen is doing anything, and that it is causing GI upset. She recommends that he discontinue the Relafen and amitriptyline, take omeprazole on a temporary basis, and start a trial of gabapentin. There is a 5/9/14 note from a third PA which documents that the patient had had a pain flare-up. She adds Relafen back into the medication regimen with the rationale that the patient's pain is still a little high. She makes no reference to the previous provider's statements regarding lack of effectiveness and side effects of Relafen. There is a note dated 5/15/14 from the nurse practitioner which states that the patient is doing fine without the Relafen and amitriptyline, and that the gabapentin was helpful. The final note in the records, dated 7/7/14, is signed by the PA who re-started Relafen. It makes no comment regarding whether or not the Relafen has been effective, and notes that he "gets some GI upset but omeprazole prevents that". Relafen was dispensed at the visit. All of these progress notes document that the patient is not working, and comment that medications allow him to perform exercise and activities of daily living. When specified, the ADLs appear to include grooming himself, doing dishes and taking out the garbage. Although cleaning is listing among

the activities he is able to perform, it is not clear that he does so. The exercise consists of walking and going to the gym, and appears to be decreasing with time. Earlier notes document that he goes to the gym several days per week and walks or rides his bike 30 minutes three times per week. The last note states that he goes to the gym for 15 minutes twice per week and walks, duration and frequency unspecified. All of the notes document that the patient's pain level without medication is 9-10/10, and that it is 6-8/10 with medications.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retrospective request for Relafen 750mg, qty 60, DOS 07/07/2014: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Goodman and Gilman's The Pharmacological Basis of Therapeutics, 12th Edition, McGraw-Hill, 2006; Physician's Desk Reference, 68th Edition; www.rxlist.com; Official Disability Guidelines Drug Formulary, www.odg-twc.com/odgtwcfomulary.htm; drugs.com; Epocrates Online, www.epocrates.com; Monthly Prescribing Reference, www.empr.com; Opioid Dose Calculator - AMDD Agency Medical Directors' Group Dose Calculator, www.agencymeddirectors.wa.gov (as applicable)

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines , Medications for Chronic Pain, NSAIDs (non-steroidal anti-inflammatory drugs), Chronic low back.

Decision rationale: The MTUS guidelines cited above states that medications should be started individually while other treatments are held constant, with careful assessment of function. There should be functional improvement with each medication in order to continue it. The MTUS references regarding NSAIDs state that NSAIDs are recommended as an option for short-term symptomatic relief. A Cochrane review found that NSAIDs were no more effective than acetaminophen, narcotics or muscle relaxants; and that they were likely to have more side effects than acetaminophen and fewer side effects than narcotics or muscle relaxants. NSAIDs may be used to treat breakthrough and mixed pain conditions such as osteoarthritis with neuropathic pain, but there is only inconsistent evidence to support their use for long-term neuropathic pain. Clinicians should weight the indications for NSAIDs against both GI and cardiovascular risk factors. 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. This reference notes that long-term PPI use has been shown to increase the risk of hip fracture. NSAIDs are relatively contraindicated in patients with renal insufficiency or cirrhosis. The clinical findings in this case do not support the continued use of Relafen. It is not clear how long the patient has been taking it, but it is clear that it has been at least 8 months, which is long-term use. Since drugs such as amitriptyline and gabapentin are being used in this case, the patient's pain must be considered to be neuropathic. During the time he has been taking Relafen the patient's level of function, which was marginal at best, appears to have deteriorated rather than improved. There appears to have been no significant improvement

in the patient's pain levels during the time he was taking Relafen. There is no documentation of any assessment of GI or cardiovascular risk. There is documentation that the patient feels that Relafen is not helping him, and that it is causing GI side effects. The Relafen was stopped by one provider and restarted three weeks later by another. The follow up note by the second provider states that the patient "gets GI upset but omeprazole prevents that". It would seem obvious that if omeprazole were preventing GI upset, the patient would not be experiencing it. Based on the guidelines above and the clinical findings in this case, Relafen 750 #60 DOS7/7/14 was not medically necessary. Relafen was not medically necessary because its use did not result in functional improvement, because long-term use of an NSAID is not indicated for radicular pain, because there is no documentation of an appropriate evaluation for GI and CV risk factors, because Relafen appears to be causing GI side effects even with Omeprazole, and because the patient is documented as stating that it is ineffective.