

<b>Case Number:</b>	CM14-0151089		
<b>Date Assigned:</b>	09/19/2014	<b>Date of Injury:</b>	11/11/1997
<b>Decision Date:</b>	10/20/2014	<b>UR Denial Date:</b>	09/04/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/16/2014

### 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 Physical Medicine & Rehabilitation, has a subspecialty in Pain 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:

The injured worker is a 57 year-old male with a date of injury of 11/11/1997. The patient's industrially related diagnoses include right inguinal post herniorrhaphy, syndrome, s/p right inguinal herniorrhaphy repair x2, chronic pain disorder with elements of systemic somatization, psychiatrist problems, medication induced gastritis, possible restless leg syndrome, and coronary disease s/p coronary bypass/graft vessel on 1/27/2014 what was deemed industrially related. The disputed issues are Anaprox DS 550mg #60, Norco 10/325mg #60, and Fexmid 7.5mg #60. A utilization review determination on 9/4/2014 had non-certified these requests. The stated rationale for the denial of Anaprox DS was "the patient has a cardiovascular disease and has already undergone a bypass procedure, and is reported to have medication-induced gastritis. The request for Anaprox is not substantiated." The stated rationale for the denial of Fexmid was that although the patient presents with moyspasms, "the MTUS does not support the long-term use of muscle relaxants such as Fexmid." Lastly, the rationale for the denial of Norco was "documentation of pain relief and functional level improvements attributed to the use of this opioid was not noted in the records".

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Anaprox DS 550mg #60:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Proton pump inhibitors (PPIs).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs (non-steroidal anti-inflammatory drugs) Page(s): 67-68.

**Decision rationale:** Anaprox DS 550mg (Naproxen 550mg) is a non-steroidal anti-inflammatory drug (NSAID). The Chronic Pain Medical Treatment Guidelines state that NSAIDs are recommended at the lowest dose for the shortest period in patients with moderate to severe pain. Acetaminophen may be considered for initial therapy for patients with mild to moderate pain, and in particular, for those with gastrointestinal, cardiovascular or renovascular risk factors. Regarding cardiovascular disease, the guidelines recommend the following: "A non-pharmacological choice should be the first option in patients with cardiac risk factors. It is then suggested that acetaminophen or aspirin be used for short-term needs. An opioid also remains a short-term alternative for analgesia." Coronary artery surgery is considered a major risk factor and if NSAID therapy is necessary, the suggested treatment is naproxen plus low-dose aspirin plus a PPI. On the progress report dated 8/18/2014, the treating physician documented in the history that the injured worker had chest pain on 1/27/2014, went to ER and had a coronary bypass on the same day. The treating physician stated that the cardiologist informed the injured worker that his risk of coronary disease was likely due to his chronic oral analgesic medications along with new onset of DM, hypercholesterolemia and stress. The injured worker also has the diagnosis of medication-induced gastritis. The treating physician does state that the medication is beneficial, however, the injured worker has been taking Anaprox DS 550mg since at least March 2014. The injured worker has both cardiovascular and gastrointestinal risk factors. The guidelines state that the treating physician should weight the indications for NSAIDs against both GI and cardiovascular risk factors. However, there is no documentation that the injured worker has tried and failed non-pharmacological therapy or other first-line options (as suggested in the guidelines) since his coronary bypass. Based on the guidelines and the records provided, medical necessity for Anaprox DS 550mg #60 is not established.

**Norco 10/325 mg #60:**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74-96.

**Decision rationale:** Norco 10/325mg is an opioid that is recommended for moderate to severe pain. With regard to the use of Norco, the California Chronic Pain Medical Treatment Guidelines state the following about on-going management with opioids: "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 drug-taking 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". In the progress report dated 8/18/2014, the treating physician documented that the injured worker's pain

level was 7 out of 10 and stated that Norco helped. However, there was no documentation comparing pain level without and with the use of Norco. In the interim history, the treating physician documented that in March 2013, the injured worker went to a detoxification program and weaned off all his opiate-based narcotics, but two months later had to restart his medication, which enabled him to function on a daily basis. However, there is no documentation of current objective functional improvement with the use of Norco. According to the guidelines, it is appropriate to discontinue opioids if there is no overall improvement in function, decrease in function, or intolerable adverse effects. Due to lack of adequate documentation of the four domains for on-going management of pain with opioids, Norco 10/325mg #60 is not medically necessary at this time.

**Fexmid 7.5mg #60:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants, Cyclobenzaprine (Fexmid) Page(s): 63-64.

**Decision rationale:** Cyclobenzaprine (Fexmid) is a skeletal muscle relaxant and a central nervous system depressant. The Chronic Pain Medical Treatment Guidelines recommend "non-sedating muscle relaxants with caution as a second-line option for short-term treatment of acute exacerbations in patients with chronic LBP." According to studies, the greatest effects appear in the first 4 days of treatment. Due to limited and mixed-evidence, the guidelines do not recommend Cyclobenzaprine for chronic use. In general, efficacy of muscle relaxants can diminish over time, and prolonged use of some medications in this class may lead to dependence. Side effects of Fexmid include sedation and headaches. On the progress report dated 8/18/2014, the treating physician documented that the injured worker experienced muscle spasms over the low back, which affected his ability to sleep. He used Fexmid intermittently and reported that it worked well. The treating physician documented positive physical findings of taut bands throughout the lumbar paraspinal muscles. Although the treating physician documented that Fexmid was prescribed for PRN use, the available records show that the injured worker has been on Fexmid since 3/10/2014 and the records state that he also received another prescription on 7/16/2014. According to the guidelines, Fexmid can be recommended for only short-term use. Furthermore, the guidelines recommend that this medication should be avoided in people with recent myocardial infarction. Therefore, Fexmid 7.5mg #60 is not medically necessary.