

<b>Case Number:</b>	CM14-0157803		
<b>Date Assigned:</b>	10/01/2014	<b>Date of Injury:</b>	07/25/2013
<b>Decision Date:</b>	10/29/2014	<b>UR Denial Date:</b>	09/15/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/25/2014

### 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 Occupational 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 34 year old male executive who injured his back at work on 25 Jul 2013 when he lifted 2 boxes weighing about 50-60 lbs. He felt a pop in his lower back and had immediate low back pain with radiation into posterior right leg to level of the knee. He was diagnosed with a sprain in the lumbar region. Since then he developed mental health changes attributed this injury and diagnosed as adjustment reactions with mixed emotions. His pain presently is 4-7/10 in intensity with continued radiation into right lower extremity. There is tingling in the right ankle region and numbness in posterior right thigh. He has frequent flare-ups associated with activities of daily living and prolonged sitting. Examination showed positive straight leg raise on the right at 60 degrees, decreased range of motion to 75 degrees flexion, 30 degrees lateral flexion and 15 degrees rotation. His lower extremity reflexes were normal. X-ray of lumbosacral spine (13 Aug 2014) was normal. Lumbar MRI (7 Aug 2014) showed minimal degenerative changes at L5-S1 without right foraminal narrowing. Lumbar MRI (9 Aug 2013) was performed but the records were not available for review. Treatment included physical therapy (over 30 sessions but without sustained improvement in symptoms), acupuncture (15 treatments but without sustained improvement in symptoms), lumbar epidural steroid injection (one injection - gave up to 12 weeks of lessening of pain) and medications (Norco 10/325 to use as needed - documented monthly use since Apr 2014, Terocin patches, gabapentin, ibuprofen, Duexis (Famotidine combined with ibuprofen), Naprosyn, omeprazole, Flurbiprofen cream, Ambien, Xanax, tramadol cream). Three drug screens showed negative for narcotic use. At the last visit to the provider (Aug 2014), the patient was returned to work with light duty restrictions.

### IMR ISSUES, DECISIONS AND RATIONALES

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

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

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 79. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Chapter, Norco

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment Page(s): 49, Chronic Pain Treatment Guidelines (CPMTG) Part 2, Page(s): 60,74-96.

**Decision rationale:** Norco is a mixed medication made up of the opioid, hydrocodone, and acetaminophen, better known as Tylenol. It is recommended for moderate to moderately severe pain with usual dosing of 5-10 mg hydrocodone per 325 mg of acetaminophen taken as 1-2 tablets every 4-6 hours. Maximum dose according to the MTUS is limited to 4 gm of acetaminophen per day which is usually 60mg/day of hydrocodone. According to the MTUS, opioid therapy for control of chronic pain, while not considered first line therapy, is considered a viable alternative when other modalities have been tried and failed. Success of this therapy is noted when there is significant improvement in pain or function. The risk with this therapy is the development of addiction. The pain guidelines in the MTUS directly address this issue and have a number of recommendations to identify when addiction develops and to prevent addiction from occurring. Although the care for this patient does not document all these recommended actions, it does note the improvement in pain adequate enough to return the patient to work. The patient's use of Norco is on an as needed basis and frequent monitoring of the patient does not reveal narcotics in the urine suggesting that the patient indeed uses the medication only when needed and not on a regular basis. The records also document stability in dosing, in that the same dose of opioid the patient was started on in April 2014 is still in present use. This is not the pattern you will see in addiction. Since the patient is not displaying signs of addiction, the medication is effective in lowering the patient's pain and the patient is being appropriately monitored by the treating provider, chronic use of opioids in this instance is not contraindicated. Such as, Norco 10/325mg #60 is medically necessary.

**Duexis 800mg #90:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain, Duexis

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment, Chapter 12 Low Back Complaints Page(s): 47-9,287-9,308, Chronic Pain Treatment Guidelines Page(s): 11-2,2-60,67-73.

**Decision rationale:** Duexis is a combination of the NSAID, ibuprofen 800 mg, and the histamine-2 receptor (H-2) blocker, Famotidine 26.6 mg. It is used to provide gastric protection for patients requiring NSAID use. NSAIDs treat mild to moderate pain and are most effective within the first few weeks of therapy initiation. According to the MTUS, use of NSAIDs for

chronic low back pain is no more effective than acetaminophen. In fact, NSAIDs may actually delay healing when used chronically. Because of the potential for gastric and renal injury, NSAIDs are best used for intermittent or short-term symptom relief. If the concern for use of a NSAID is due to symptoms of heartburn or gastric upset then a proton pump inhibitor (PPI) or H-2 blocker can be added to the therapy. The MTUS does not address Duexis specifically but notes treatment of dyspepsia caused by NSAIDs can be accomplished with either an H-2 Blocker or a PPI. An H-2 blocker may be the better choice for chronic use since PPIs have more clinically significant drug interactions and adverse events (e.g. interaction with clopidogrel, fracture, pneumonia, Clostridium difficile infection). Also studies of ibuprofen have shown little improvement in pain control with doses greater than 400 mg unless treating arthritis such as rheumatoid arthritis or osteoarthritis. Use of Duexis will limit the dose of NSAID to the highest dose (800 mg/tablet) thus increasing the risk of gastric irritation. There is no advantage of using a combination medication, such as Duexis, over using the same medications as single prescriptions other than a drop in the number of pills taken and perhaps better compliance with gastro-protective therapy. Use of this medication limits provider control on the strength of NSAID used. Both ibuprofen and Famotidine are available as prescriptions and over the counter, and in lower doses. Of note, acetaminophen has much less side effects than NSAIDs so may be a better option for long term pain control. Although it can cause liver inflammation at high doses, the treating provider can avoid this by appropriate dose management. Such as, Duexis 800mg #90 is not medically necessary.