

<b>Case Number:</b>	CM14-0026393		
<b>Date Assigned:</b>	06/16/2014	<b>Date of Injury:</b>	07/11/2005
<b>Decision Date:</b>	08/13/2014	<b>UR Denial Date:</b>	02/03/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/03/2014

### 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 Anesthesiology, has a subspecialty in Pain Medicine and is licensed to practice in Massachusetts. 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:

According to the records for review, the patient is a 49-year-old male with a date of injury of July 11, 2005. The patient's sustained an injury involving the cervical spine and developed upper extremity radicular pain. The patient is noted to have cervical and lumbar musculoskeletal pain, positive radicular signs in the cervical spine, positive shoulder impingement in the right shoulder, and upper chimney ridiculous signs. The patient is currently being treated the multimodal pain medication regimen consisting of muscle relaxants, topical ointment and opioids. A request for Fexmid, Prilosec, Nucynta, and a urine drug screen was requested and denied.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**FEXMID 7.5 MG #90:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines CYCLOBENZAPRINE (FLEXERIL, AMRIX, FEXMID, GENERIC AVAILABLE.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Pain Interventions and Treatments Page(s): 41-42. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Muscle relaxants for pain.

**Decision rationale:** According to the MTUS and the ODG for muscle relaxants, current treatment guidelines recommend this medication is an option for chronic pain using a short course of therapy. The effect of Fexmid is greatest in the first four days of treatment, suggesting a shorter course as many better. This medication is not recommended as an addition to other medications. Longer course of Fexmid also are not recommended to be for longer than 2 to 3 weeks as prolonged use may lead to dependence. Therefore, at this time, the requirements for treatment have not been met and medical necessity has not been established.

**PRILOSEC 20 MG #60:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS, GI SYMPTOMS & CARDIOVASCULAR RISK.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Pain Interventions and Treatments Page(s): 68-69.

**Decision rationale:** The MTUS makes the following recommendations for the use of proton pump inhibitors. The clinicians should weight the indications for NSAIDs against both GI and cardiovascular risk factors. Determine if the patient is at risk for GI events, which included patients that are greater than 65 years of age; history of peptic ulcer, GI bleeding or perforation; concurrent use of Aspirin (ASA), corticosteroids, and/or an anticoagulant; or 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. The recommendations are patients with no risk factor and no cardiovascular disease, non-selective NSAIDs OK (e.g, ibuprofen, naproxen, etc.), patients at intermediate risk for GI events and no cardiovascular disease, such as, 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 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 GI events with no cardiovascular disease: A Cox-2 selective agent plus a PPI if absolutely necessary. Patients at high risk of GI events with cardiovascular disease has to show the following, if GI risk is high the suggestion is for a low-dose Cox-2 plus low dose Aspirin (for cardioprotection) and a PPI. If cardiovascular risk is greater than GI risk the suggestion is naproxyn plus low-dose aspirin plus a PPI. Cardiovascular disease is 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. Major risk factors (recent MI, or coronary artery surgery, including recent stent placement): If NSAID therapy is necessary, the suggested treatment is naproxyn plus low-dose aspirin plus a PPI would have mild to moderate risk factors that include if long-term or high-dose therapy is required, full-dose naproxen (500 mg twice a day) appears to be the preferred choice of NSAID. If naproxyn is ineffective, the suggested treatment is the addition of aspirin to naproxyn plus a PPI, or a low-dose Cox-2 plus ASA. According to the records available for review the patient does not meet any of the guidelines required for the use of this medication therefore, at this time, the requirements for treatment have not been met and medical necessity has not been established.

**NUCYNTA 50 MG #120:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines OPIOIDS, LONG TERM ASSESSMENT.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74-97.

**Decision rationale:** According to the MTUS Chronic Pain Medical Treatment Guidelines section on opioids page 74-97, On-Going Management, prescriptions from a single practitioner taken as directed, and all prescriptions from a single pharmacy. The lowest possible dose should be prescribed to improve pain and function. 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 includes 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 non-adherent) 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.(Passik, 2000). Home: To aid in pain and functioning assessment, the patient should be requested to keep a pain diary that includes entries such as pain triggers, and incidence of end-of-dose pain. It should be emphasized that using this diary will help in tailoring the opioid dose. This should not be a requirement for pain management. Use of drug screening or inpatient treatment with issues of abuse, addiction, or poor pain control. Documentation of misuse of medications (doctor-shopping, uncontrolled drug escalation, drug diversion). Continuing review of overall situation with regard to nonopioid means of pain control. 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. According to the documents available for review, there is no current documentation of baseline pain, pain score with use of opioids, functional improvement on current regimen, side effects. Additionally, according to the documents available for review, there is no evidence of a pain consultation despite the fact that the patient is been maintained on opiates for greater than three months. Therefore, at this time, the requirements for treatment have not been met and medical necessity has not been established.

**ONE URINE DRUG SCREEN:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines SUBSTANCE ABUSE (TOLERANCE, DEPENDENCE, ADDICTION).

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain (Chronic), Drug Testing.

**Decision rationale:** According to the ODG, urine drug testing is recommended as a tool to monitor compliance with prescribed substances, identify use of undisclosed substances, and uncover diversion of prescribed substances. The test should be used in conjunction with other clinical information when decisions are to be made to continue, adjust or discontinue treatment. This information includes clinical observation, results of addiction screening, pill counts, and prescription drug monitoring reports. The prescribing clinician should also pay close attention to information provided by family members, other providers and pharmacy personnel. The frequency of urine drug testing may be dictated by state and local laws. According to documents available for review, the patient meets none of the above mentioned indications for your drug test. Therefore, at this time, the requirements for treatment have not been met and medical necessity has not been established.