

Case Number:	CM14-0011515		
Date Assigned:	02/21/2014	Date of Injury:	05/13/1991
Decision Date:	02/05/2015	UR Denial Date:	01/15/2014
Priority:	Standard	Application Received:	01/28/2014

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 Practice and is licensed to practice in Colorado. 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:

66 year old male with date of injury 5/13/1991 continues care with treating physician. Patient complaints include low back pain radiating to both legs, neck pain with headaches and bilateral arm pain. Diagnoses include Lumbar Post-laminectomy syndrome with bilateral lower extremity radiculopathy, Cervical radiculopathy, and Failed Spinal Cord Stimulator / Intrathecal Pump. Cervical and Lumbar epidural steroid injections have helped in the past, but did not last. Patient is maintained on regimen including Norco, Motrin, Lyrica, and Baclofen as January 2014 physician notes. Patient also takes Prilosec for documented risks factors for adverse gastrointestinal events: age, non-steroidal drug use, and smoking, per physician notes January 2014. The treating physician requests Independent Medical Review for Utilization Review denial of refills on Prilosec, Norco, and Baclofen.

IMR ISSUES, DECISIONS AND RATIONALES

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

PRILOSEC 20 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 Pain Interventions and Treatments. Page(s): 68.

Decision rationale: Per the MTUS Guidelines, Prilosec and other Proton pump inhibitors can be indicated for use with non-steroidal anti-inflammatory drugs, in those at high risk for gastrointestinal events, or in those on high dose / multiple medications that increase risk of gastrointestinal events. To determine if a patient is at risk for adverse gastrointestinal events, the guidelines establish criteria to consider: (1) age > 65 years; (2) history of peptic ulcer, GI bleeding or perforation; (3) concurrent use of ASA, corticosteroids, and/or an anticoagulant; or (4) high dose/multiple NSAID (e.g., NSAID + low-dose ASA). For the patient of concern, the records do not indicate any diagnosis that would warrant Prilosec use. The most recent records available for review are dated January 2014, so there is not current documentation that patient still takes non-steroidal anti-inflammatory drug which would increase risk of adverse gastrointestinal events. Patient has no known diagnosis of gastrointestinal symptoms. Without evidence that patient takes non-steroidal anti-inflammatory drug or has history of gastrointestinal issues, the request for Prilosec is not medically indicated based on lack of documentation for its need. The request is not medically necessary.

BACLOFEN 10 MG ONE TABLET X2 A DAY #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 Pain Interventions and Treatments. Page(s): 63-64.

Decision rationale: Per the Guidelines, muscle relaxers are recommended, as second line therapy for low back pain, primarily acute exacerbations of chronic issue. (Muscle relaxers are prescribed, however, for many musculoskeletal conditions) Some evidence suggests that muscle relaxers may help decrease pain and muscle spasm, and may increase mobility, but those effects are short lived. No benefit has been shown when muscle relaxers are added to non-steroidal anti-inflammatory drugs for pain. Appropriate effects of muscle relaxers diminish over time, and long term use with some can lead to dependence. Therefore, though these medications are commonly prescribed for a variety of conditions, they are not recommended as primary treatment for chronic painful musculoskeletal conditions. Of the muscle relaxers available, those with the least evidence to support their use include chlorzoxazone, methocarbamol, dantrolene and baclofen. (Chou, 2004) Baclofen is classified as an anti-spasticity drug, per the Guidelines, and works at the pre-synaptic and post-synaptic levels for GABA receptors. It is indicated to treat spasms and spasticity related to multiple sclerosis and spinal cord injuries, and has been used off label for paroxysmal neuropathy such as trigeminal neuralgia. Recommended dosing for Baclofen is 5mg 3 times per day, to titrate up as needed. Baclofen should not be abruptly discontinued due to possible hallucinations / seizures that may develop. For the patient of concern, the Baclofen is intended to be used for back and neck pain with related spasms. The most recent records supplied are dated January 2014, so there is no evidence of how long this patient has been taking Baclofen, its effects, or if patient is taking routinely. Furthermore, patient does not have spasticity or spinal cord injury / multiple sclerosis, so Baclofen has little support for its use in this patient's condition. It is unclear in the record exactly how the Baclofen here is to be dosed, but the requested strength of 10mg tablet exceeds the starting dose

recommended for Baclofen. Without documentation of how this medication is being used and of its effects / efficacy, the Baclofen is not medically necessary.

NORCO 10/325 MG #180: 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 Pain Interventions and Treatments. Page(s): 79-80, 85, 88-89, 91.

Decision rationale: The Guidelines establish criteria for use of opioids, including long term use (6 months or more). When managing patients using long term opioids, the following should be addressed: Re-assess the diagnosis and review previous treatments and whether or not they were helpful. When re-assessing, pain levels and improvement in function should be documented. Pain levels should be documented every visit. Function should be evaluated every 6 months using a validated tool. Adverse effects, including hyperalgesia, should also be addressed each visit. Patient's motivation and attitudes about pain / work / interpersonal relationships can be examined to determine if patient requires psychological evaluation as well. Aberrant / addictive behavior should be addressed if present. Do not decrease dose if effective. Medication for breakthrough pain may be helpful in limiting overall medication. Follow up evaluations are recommended every 1-6 months. To summarize the above, the 4A's of Drug Monitoring (analgesia, activities of daily living, adverse side effects, and aberrant drug-taking Behaviors) have been established. 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) Several circumstances need to be considered when determining to discontinue opioids: 1) Verify patient has not had failure to improve because of inappropriate dosing or under-dosing of opioids. 2) Consider possible reasons for immediate discontinuation including diversion, prescription forgery, illicit drug use, suicide attempt, arrest related to opioids and aggressive or threatening behavior in clinic. Weaning from the medication over 30 day period, under direct medical supervision, is recommended unless a reason for immediate discontinuation exists. If a medication contract is in place, some physicians will allow one infraction without immediate discontinuation, but the contract and clinic policy should be reviewed with patient and consequences of further violations made clear to patient. 3) Consider discontinuation if there has been no improvement in overall function, or a decrease in function. 4) Patient has evidence of unacceptable side effects. 5) Patient's pain has resolved. 6) Patient exhibits "serious non-adherence." Per the Guidelines, Chelminski defines "serious substance misuse" or non-adherence as meeting any of the following criteria: (a) cocaine or amphetamines on urine toxicology screen (positive cannabinoid was not considered serious substance abuse); (b) procurement of opioids from more than one provider on a regular basis; (c) diversion of opioids; (d) urine toxicology screen negative for prescribed drugs on at least two occasions (an indicator of possible diversion); & (e) urine toxicology screen positive on at least two occasions for opioids not routinely prescribed. (Chelminski, 2005) 7) Patient requests discontinuing opioids. 8) Consider verifying that patient is in consultation with physician specializing in addiction to consider detoxification if patient continues to violate the medication contract or shows other signs of abuse / addiction. 9) Document the basis for decision to discontinue

opioids. Likewise, when making the decision to continue opioids long term, consider the following: Has patient returned to work? Has patient had improved function and decreased pain with the opioids? For the patient of concern, the records supplied do not indicate any monitoring or assessment since last note supplied, dated January 2014. The notes from January 2014 indicate patient has a pain contract, performs UDS and CURES reviews, and achieves some relief from medication regimen which at the time included Norco. However, as no records are available since January 2014, there is no evidence that patient is continuing to be monitored / tested, and no evidence that medications are still effective. Without any evidence of efficacy or appropriate monitoring, the request for Norco is not medically necessary.