

Case Number:	CM14-0139235		
Date Assigned:	09/05/2014	Date of Injury:	10/23/2012
Decision Date:	01/23/2015	UR Denial Date:	08/15/2014
Priority:	Standard	Application Received:	08/28/2014

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 Internal Medicine, and is licensed to practice in District of Columbia. 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 44 year old patient who sustained injury on Oct 23 2012. He suffered from right elbow strain and right shoulder sprain. He was found to have normal x-rays of the right elbow and right shoulder and cervical spine in May 15 2013. He was found to have a normal MRI of the right shoulder on Jan 30 2013 and right elbow MRI on Nov 8 2013 which showed mild tendonitis. He was diagnosed with possible cervical radiculopathy. He was prescribed Naproxen, Protonix, Tramadol and Fexmid. He was also prescribed urine drug testing on Aug 6 2014 by treating provider.

IMR ISSUES, DECISIONS AND RATIONALES

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

Full panel drug screen: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG); Pain Procedure Summary Urine Drug Testing

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 43,89.

Decision rationale: Per MTUS, this is recommended as an option, using a urine drug screen to assess for the use or the presence of illegal drugs. For more information, see Opioids, criteria for

use: (2) Steps to take before a therapeutic trial of opioids & (4) On-going management; opioids, differentiation: dependence & addiction; opioids, screening for risk of addiction (tests); & opioids, steps to avoid misuse/addiction. As per MTUS guidelines, Urine drug testing should be done 2 times per year and the frequency can be increased if there are signs of abuse or addiction. Indicators and predictors of possible misuse of controlled substances and/or addiction: 1) Adverse consequences: (a) Decreased functioning, (b) Observed intoxication, (c) Negative affective state, 2) Impaired control over medication use: (a) Failure to bring in unused medications, (b) Dose escalation without approval of the prescribing doctor, (c) Requests for early prescription refills, (d) Reports of IMR Medical Professional Reviewer's MPR Form Effective lost or stolen prescriptions, (e) Unscheduled clinic appointments in "distress", (f) Frequent visits to the ED, (g) Family reports of overuse of intoxication 3) Craving and preoccupation: (a) Non-compliance with other treatment modalities, (b) Failure to keep appointments, (c) No interest in rehabilitation, only in symptom control, (d) No relief of pain or improved function with opioid therapy, (e) Overwhelming focus on opiate issues. 4) Adverse behavior: (a) Selling prescription drugs, (b) Forging prescriptions, (c) Stealing drugs, (d) Using prescription drugs in ways other than prescribed (such as injecting oral formulations), (e) Concurrent use of alcohol or other illicit drugs (as detected on urine screens), (f) Obtaining prescription drugs from non-medical sources. Based on the clinical documentation provided, urine drug testing would not be indicated as the patient had no signs of abuse or addiction/abuse. The patient had two prior drug screens which were negative. Further testing would not be indicated.

Anaprox-DS Naproxen Sodium 550mg #90: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 73.

Decision rationale: Per MTUS, Naproxen (Naprosyn): delayed release (EC-Naprosyn), as Sodium salt (Anaprox, Anaprox DS, Aleve [OTC]) Generic available; extended-release (Naprelan): 375 mg. Different dose strengths and formulations of the drug are not necessarily bioequivalent. Dosing Information: Osteoarthritis or ankylosing spondylitis: Dividing the daily dose into 3 doses versus 2 doses for immediate-release and delayed-release formulations generally does not affect response. Morning and evening doses do not have to be equal in size. The dose may be increased to 1500 mg/day of Naproxyn for limited periods when a higher level of analgesic/anti-inflammatory activity is required (for up to 6 months). Naprosyn or Naproxyn: 250-500 mg PO twice daily. Anaprox: 275-550 mg PO twice daily. (Total dose may be increased to 1650 mg a day for limited periods). EC-Naprosyn: 375 mg or 500 mg twice daily. The tablet should not be broken, crushed or chewed to maintain integrity of the enteric coating. Naprelan: Two 375 mg tablets (750 mg) PO once daily or two 500 mg tablets (1000 mg) once daily. If required (and a lower dose was tolerated) Naprelan can be increased to 1500 mg once daily for limited periods (when higher analgesia is required). Pain: Naprosyn or Naproxyn: 250-500 mg PO twice daily. The maximum dose on day one should not exceed 1250 mg and 1000 mg on subsequent days. The patient was found to have evidence of sprain/strain and had self-reported

improvement without objective findings. This continued treatment would not be recommended. Therefore, the requested medication is not medically necessary.

Fexmid Cyclobenzaprine 7.5 mg #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 Page(s): 41-42, 63.

Decision rationale: Per MTUS, medication is recommended as an option, using a short course of therapy. See Medications for chronic pain for other preferred options. Cyclobenzaprine (Flexeril) is more effective than placebo in the management of back pain; the effect is modest and comes at the price of greater adverse effects. The effect is greatest in the first 4 days of treatment, suggesting that shorter courses may be better. Treatment should be brief. There is also a post-op use. The addition of cyclobenzaprine to other agents is not recommended. Cyclobenzaprine-treated patients with fibromyalgia were 3 times as likely to report overall improvement and to report moderate reductions in individual symptoms, particularly sleep. Note: Cyclobenzaprine is closely related to the tricyclic antidepressants, e.g., Amitriptyline. See Antidepressants. Cyclobenzaprine is associated with a number needed to treat of 3 at 2 weeks for symptom improvement in LBP and is associated with drowsiness and dizziness. Cyclobenzaprine is a skeletal muscle relaxant and a central nervous system (CNS) depressant that is marketed as Flexeril by [REDACTED]. Cyclobenzaprine (Flexeril, Amrix, Fexmid TM, generic available): Recommended for a short course of therapy. Limited, mixed-evidence does not allow for a recommendation for chronic use. Cyclobenzaprine is a skeletal muscle relaxant and a central nervous system depressant with similar effects to tricyclic antidepressants (e.g. amitriptyline). Cyclobenzaprine is more effective than placebo in the management of back pain, although the effect is modest and comes at the price of adverse effects. It has a central mechanism of action, but it is not effective in treating spasticity from cerebral palsy or spinal cord disease. Cyclobenzaprine is associated with a number needed to treat of 3 at 2 weeks for symptom improvement. The greatest effect appears to be in the first 4 days of treatment. Cyclobenzaprine has been shown to produce a modest benefit in treatment of fibromyalgia. Cyclobenzaprine-treated patients with fibromyalgia were 3 times more likely to report overall improvement and to report moderate reductions in individual symptoms (particularly sleep). A meta-analysis concluded that the number needed to treat for patients with fibromyalgia was 4.8. Side Effects: Include anticholinergic effects (drowsiness, urinary retention and dry mouth). Sedative effects may limit use. Headache has been noted. This medication should be avoided in patients with arrhythmias, heart block, heart failure and recent myocardial infarction. Side effects limit use in the elderly. This medication is not recommended to be used for longer than 2-3 weeks. Per guidelines cited and from review of the clinical documentation provided, long term usage of this medication would not be indicated.

Ultram Tramadol, HCL ER 150mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioid Use for Chronic Pain.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 83,93-94.

Decision rationale: Per MTUS, Tramadol: A recent Cochrane review found that this drug decreased pain intensity, produced symptom relief and improved function for a time period of up to three months but the benefits were small (a 12% decrease in pain intensity from baseline). Adverse events often caused study participants to discontinue this medication, and could limit usefulness. There are no long-term studies to allow for recommendations for longer than three months. Similar findings were found in an evaluation of a formulation that combines immediate-release vs. extended release Tramadol. Adverse effects included nausea, constipation, dizziness/vertigo and somnolence. Tramadol (Ultram; Ultram ER; generic available in immediate release tablet): Tramadol is a synthetic opioid affecting the central nervous system. Tramadol is not classified as a controlled substance by the DEA. Side Effects: Dizziness, nausea, constipation, headache, somnolence, flushing, pruritus, vomiting, insomnia, dry mouth, and diarrhea. Tramadol may increase the risk of seizure especially in patients taking SSRIs, TCAs and other opioids. Do not prescribe to patients that at risk for suicide or addiction. Warning: Tramadol may produce life-threatening serotonin syndrome, in particular when used concomitantly with SSRIs, SNRIs, TCAs, and MAOIs, and triptans or other drugs that may impair serotonin metabolism. Analgesic dose: Tramadol is indicated for moderate to severe pain. The immediate release formulation is recommended at a dose of 50 to 100mg PO every 4 to 6 hours (not to exceed 400mg/day). This dose is recommended after titrating patients up from 100mg/day, with dosing being increased every 3 days as tolerated. For patients in need of immediate pain relief, which outweighs the risk of non-tolerability the initial starting dose, may be 50mg to 100mg every 4 to 6 hours (max 400mg/day). Ultram ER: Patient currently not on immediate release Tramadol should be started at a dose of 100mg once daily. The dose should be titrated upwards by 100mg increments if needed (Max dose 300mg/day). Patients currently on immediate release Tramadol calculate the 24-hour dose of IR and initiate a total daily dose of ER rounded to the next lowest 100mg increment (Max dose 300mg/day). (Product information, ██████████ 2003) (Lexi-Comp, 2008) Per guidelines above, the patient had ongoing pain despite this medication and it would not be medically indicated for long term usage. Therefore, the medication is not medically necessary.

Protonix Pantoprazole 20mg #60: Upheld

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

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

Decision rationale: This patient had no evidence of gastrointestinal or cardiovascular risk factors and this treatment would not be recommended. Per MTUS, Recommend with precautions as indicated below. Clinicians should weight the indications for NSAIDs against both GI and

cardiovascular risk factors. Determine if the patient is at risk for gastrointestinal events: (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). This patient had no evidence of gastrointestinal or cardiovascular risk factors and this treatment would not be recommended. Therefore, the request for Protonix Pantoprazole 20mg #60 is not medically necessary and appropriate.