

<b>Case Number:</b>	CM14-0216837		
<b>Date Assigned:</b>	01/06/2015	<b>Date of Injury:</b>	04/04/2011
<b>Decision Date:</b>	08/25/2015	<b>UR Denial Date:</b>	11/25/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/26/2014

### 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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: Massachusetts

Certification(s)/Specialty: Anesthesiology, Pain Management

### 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 71 year old male, who sustained an industrial injury on 4/4/11. The injured worker has complaints of headaches and neck pain that radiates into the right shoulder with numbness and tingling in the hands and fingers and weakness of the upper extremities and hands. The injured worker has complaints of middle back pain that radiates into the right shoulder and low back pain that radiates into the legs and both feet. The documentation noted that there is tenderness noted in the cervical paraspinal region on the right and midline cervical region. The documentation noted that there is spurlings test is painful on the right. There is present with range of motion of the cervical spine and trapezial tenderness is present. There is tenderness noted in the lumbar paraspinal region and tenderness noted in the midline lumbar spine. The diagnoses have included neck pain with degenerative disc disease causing bilateral mild-to-moderate bilateral neuroforaminal stenosis at the level of C3-C4, C4-C5, C5-C6, C6-C7, C7-T1; paracervical muscle spasm and myofascial pain and low back pain with radicular symptoms to the right and left lower extremity worse on the left side. Treatment to date has included lower back and right shoulder X-rays; magnetic resonance imaging (MRI); physical therapy; chiropractor and cortisone injections in the neck and right shoulder. The documentation noted that injections were suspended due to high blood sugars. The request was for tramadol/gabapentin/menthol/camphor/capsaicin 120g; baclofen 20mg #60; prilosec #60 and norco 10/325mg #60.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Tramadol/Gabapentin/Menthol/Camphor/Capsaicin 120g: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topicals Page(s): 111-113.

**Decision rationale:** According to the MTUS, there is little to no research to support the use of topical compounded creams. It also contains menthol, a non-recommended topical agent. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. The use of these compounded agents requires knowledge of the specific analgesic effect of each agent and how it will be useful for the specific therapeutic goal required. Topical analgesics are largely experimental and there are a few randomized controlled trials to determine efficacy or safety. Therefore, at this time, the requirements for treatment have not been met and the treatment is not medically necessary.

**Baclofen 20mg #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 Baclofen Page(s): 64.

**Decision rationale:** According to the MTUS, Baclofen is recommended orally for the treatment of spasticity and muscle spasm related to multiple sclerosis and spinal cord injuries. Baclofen has been noted to have benefits for treating lancinating, paroxysmal neuropathic pain (trigeminal neuralgia, non- FDA approved). (ICSI, 2007). According to the documents available for review, IW has none of the MTUS / FDA recommended indications for the use of this medication. Therefore, at this time, the requirements for treatment have not been met and the treatment is not medically necessary.

**Prilosec #60: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI Symptoms and Cardiovascular Risk.

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

**Decision rationale:** The MTUS makes the following recommendations for the use of proton pump inhibitors. Clinicians should weight the indications for NSAIDs against both GI and cardiovascular risk factors. Determine if the injured worker 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). Recent studies tend to show that H. Pylori does not act

synergistically with NSAIDS to develop gastroduodenal lesions. Recommendations Injured workers with no risk factor and no cardiovascular disease: Non-selective NSAIDs OK (e.g, ibuprofen, naproxen, etc.) Injured workers at intermediate risk for gastrointestinal events and no cardiovascular disease: (1) 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 (2) 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). Injured workers at high risk for gastrointestinal events with no cardiovascular disease: A Cox-2 selective agent plus a PPI if absolutely necessary. Injured workers at high risk of gastrointestinal events with cardiovascular disease: 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: A non-pharmacological choice should be the first option in injured workers 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. Mild to moderate risk factors: 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 (1) the addition of aspirin to naproxyn plus a PPI, or (2) a low-dose Cox-2 plus ASA. According to the records available for review the injured worker 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 the treatment is not medically necessary.

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

**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): 74-97.

**Decision rationale:** According to the MTUS Chronic Pain Medical Treatment Guidelines section on Opioids, On-Going Management, p 74-97: (a) Prescriptions from a single practitioner taken as directed, and all prescriptions from a single pharmacy. (b) The lowest possible dose should be prescribed to improve pain and function. (c) Office: 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 injured worker'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 injured worker's response to treatment. The 4 A's for Ongoing Monitoring: Four domains have been proposed as most relevant for ongoing monitoring of chronic pain injured workers 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)

(d) Home: To aid in pain and functioning assessment, the injured worker 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.

(e) Use of drug screening or injured worker treatment with issues of abuse, addiction, or poor pain control.

(f) Documentation of misuse of medications (doctor-shopping, uncontrolled drug escalation, drug diversion).

(g) Continuing review of overall situation with regard to non-opioid means of pain control.

(h) 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.

Additionally, the MTUS states that continued use of opioids requires (a) the injured worker has returned to work, (b) the injured worker has improved functioning and pain. There is no current documentation of baseline pain, pain score with use of opioids, functional improvement on current regimen, side effects or review of potentially aberrant drug taking behaviors as outlined in the MTUS and as required for ongoing treatment. Therefore, at this time, the requirements for treatment have not been met and the treatment is not medically necessary.