

Case Number:	CM15-0180941		
Date Assigned:	09/22/2015	Date of Injury:	03/22/2011
Decision Date:	11/13/2015	UR Denial Date:	09/08/2015
Priority:	Standard	Application Received:	09/14/2015

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: California

Certification(s)/Specialty: Emergency Medicine

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 52 year old female with a date of injury on 3-22-2011. A review of the medical records indicates that the injured worker is undergoing treatment for lumbar disc displacement without myelopathy, cervical disc displacement without myelopathy, cervicgia, osteoarthritis, localized, primary involving lower leg and depressive disorder not otherwise specified. According to the progress report dated 8-26-2015, the injured worker complained of pain in her neck, lower back and throughout the right side of her body with radiation to both legs and the right arm. The pain was associated with tingling, numbness and weakness to both legs and the right arm. She rated her best pain as six out of ten with medications and her worst pain as ten out of ten. She reported increased depression. The physical exam revealed tenderness to palpation over the bilateral lumbar paraspinal muscles consistent with spasms. There was positive lumbar facet loading maneuver bilaterally. Sensation was diminished in the right upper extremity circumferential distributions. Per the progress report dated 9-2-2015, the injured worker reported increased pain with doing activities of daily living, especially lighthouse work. She reported increased loss of sleep. Objective findings (9-2-2015) documented "+MRI's, DRE CAT cervical and lumbar, sensory loss; grip loss, loss of motion cervical and lumbar spine." Treatment has included magnetic resonance imaging (MRI), chiropractic treatment and medications. The injured worker has been prescribed Cyclobenzaprine, Omeprazole, Wellbutrin and Menthoderm gel since at least 4-29-2015. The original Utilization Review (UR) (9-8-2015) denied requests for Cyclobenzaprine, Omeprazole, Wellbutrin, Menthoderm Gel and Docuprene. Utilization Review approved a request for Nabumetone.

IMR ISSUES, DECISIONS AND RATIONALES

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

Cyclobenzaprine 7.5mg #60 DOS 08/26/2015: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Muscle relaxants (for pain).

Decision rationale: The request is for the use of a muscle relaxant to aid in pain relief. The MTUS guidelines state that the use of a medication in this class is indicated as a second-line option for short-term treatment of acute exacerbations of low back pain. Muscle relaxants may be effective in reducing pain and muscle tension, which can increase mobility. However, in most LBP cases, they show no benefit beyond NSAIDs in pain improvement. Efficacy appears to diminish over time, and prolonged use may lead to dependence. (Homik, 2004) Due to inadequate documentation of a recent acute exacerbation and poor effectiveness for chronic long-term use, the request is not medically necessary.

Omeprazole 20mg #60 DOS 08/26/2015: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): NSAIDs, GI symptoms & cardiovascular risk.

Decision rationale: The request is for the use of a medication in the class of a proton pump inhibitor. It is indicated for patients with peptic ulcer disease. It can also be used as a preventative measure in patients taking non-steroidal anti-inflammatories for chronic pain. Unfortunately, they do have certain side effects including gastrointestinal disease. The MTUS guidelines states that patients who are classified as intermediate or high risk, should be treated prophylactically. Criteria for risk are as follows: "(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)." Due to the fact the patient does not meet to above stated criteria, the request for use is not medically necessary.

Wellbutrin (bupropion) 150mg DOS08/26/2015: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Bupropion (Wellbutrin).

Decision rationale: The request is for the use of the medication welbutrin. This is a medication in the second generation non-tricyclic antidepressant class. The MTUS guidelines state the following regarding its use: Recommended as an option after other agents. While bupropion has shown some efficacy in neuropathic pain there is no evidence of efficacy in patients with non-neuropathic chronic low back pain. Furthermore, bupropion is generally a third-line medication for diabetic neuropathy and may be considered when patients have not had a response to a tricyclic or SNRI. See Antidepressants for chronic pain for general guidelines, as well as specific Bupropion listing for more information and references. In this case, the use of this medication is not supported. This is secondary to poor documentation of neuropathic pain after an initial trial of first-line therapy. As stated above, this would include medications in the class of tricyclics or SNRIs. As such, the request is not medically necessary.

Menthoderm 15% analgesic Gel 120ml DOS 08/26/2015: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS General Approaches 2004, Section(s): Initial Approaches to Treatment.

Decision rationale: The request is for the topical use of menthol. The MTUS and ACOEM as well as ODG do not comment specifically regarding this topic. The ACOEM guidelines do generally state that the use of topical analgesic therapy for pain control does not have good support regarding efficacy. In this case, the use of topical menthol would not be evidence based with poor scientific literature supporting its use for the patient's condition. As such, the request is not medically necessary.

Docuprene 100mg #60 DOS08/26/2015: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

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)/Opioid-induced constipation treatment.

Decision rationale: The request is for a medication to aid in constipation. The Official Disability Guidelines state the following regarding this topic: Recommended as indicated below. In the section, Opioids, criteria for use, if prescribing opioids has been determined to be appropriate, and then ODG recommends, under Initiating Therapy, that Prophylactic treatment of constipation should be initiated. Opioid-induced constipation is a common adverse effect of long-term opioid use because the binding of opioids to peripheral opioid receptors in the gastrointestinal (GI) tract results in absorption of electrolytes, such as chloride, with a subsequent reduction in small intestinal fluid. Activation of enteric opioid receptors also results in abnormal GI motility. Constipation occurs commonly in patients receiving opioids and can be severe enough to cause discontinuation of therapy. First-line: When prescribing an opioid,

and especially if it will be needed for more than a few days, there should be an open discussion with the patient that this medication may be constipating, and the first steps should be identified to correct this. Simple treatments include increasing physical activity, maintaining appropriate hydration by drinking enough water, and advising the patient to follow a proper diet, rich in fiber. These can reduce the chance and severity of opioid-induced constipation and constipation in general. In addition, some laxatives may help to stimulate gastric motility. Other over-the-counter medications can help loosen otherwise hard stools, add bulk, and increase water content of the stool. Second-line: If the first-line treatments do not work, there are other second-line options. About 20% of patients on opioids develop constipation, and some of the traditional constipation medications don't work as well with these patients, because the problem is not from the gastrointestinal tract but from the central nervous system, so treating these patients is different from treating a traditional patient with constipation. An oral formulation of methylnaltrexone (Relistor) met the primary and key secondary end points in a study that examined its effectiveness in relieving constipation related to opioid use for non-cancer-related pain. The effectiveness of oral methylnaltrexone in this study was comparable to that reported in clinical studies of subcutaneous methylnaltrexone in subjects with chronic non-cancer-related pain. There was an 80% improvement in response with the 450 mg dose and a 55% improvement with 300 mg. Constipation drug lubiprostone (Amitiza) shows efficacy and tolerability in treating opioid-induced constipation without affecting patients' analgesic response to the pain medications. Lubiprostone is a locally acting chloride channel activator that has a distinctive mechanism that counteracts the constipation associated with opioids without interfering with the opiates binding to their target receptors. (Bader, 2013) (Gras-Miralles, 2013) See also Tapentadol (Nucynta), which has improved gastrointestinal tolerability for patients complaining of constipation, nausea, and/or vomiting. The FDA has approved methylnaltrexone bromide (Relistor) subcutaneous injection 12 mg/0.6 mL for the treatment of opioid-induced constipation in patients taking opioids for non-cancer pain. (FDA, 2014)As stated above, measures to combat constipation for patients on opioids are needed. In this case, there is documentation stating that this medication is being prescribed to prevent opioid induced constipation. As indicated above, first-line therapy includes increasing activity, water and dietary changes. There is no documentation reflecting a discussion with the patient regarding this topic or initial non-pharmaceutical measures to be undertaken. As such, the request is not medically necessary.