

<b>Case Number:</b>	CM15-0182739		
<b>Date Assigned:</b>	09/23/2015	<b>Date of Injury:</b>	10/26/2005
<b>Decision Date:</b>	11/19/2015	<b>UR Denial Date:</b>	09/02/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/17/2015

### 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: Arizona, Michigan

Certification(s)/Specialty: Preventive Medicine, Occupational 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:

The injured worker is a 71 year old male who sustained an industrial injury on 10-26-2005. A review of medical records indicates the injured worker is being treated for discogenic lumbar condition with radicular component down the lower extremities, status post epidural injection in 2011. Medical record dated 8-26-2015 noted left knee pain. He was having difficulty with prolonged standing and walking. He had difficulty getting in and out of chair. Pain scale was unavailable. Physical examination noted tenderness across the lumbar paraspinal muscles. He could not do lumbar flexion more than 30 degrees. He could not do extension past 10 degrees. He could not do lateral tilting. He could not stand on his toes or heels due to his balance. He had pain across both knees, more so on the left on the medial greater than lateral joint line with instability. Anterior drawer test was 1-2 positive. Treatment has included medications (Norco, Ativan, and Celebrex since at least 5-13-2015 and Aciphex since 7-8-15). RFA dated 8-26-2015 requested Norco, Lorazepam, Celebrex, and Aciphex. Utilization review form dated 9-2-2015 noncertified Norco 10-325mg #90, Lorazepam 1mg #60, Celebrex 200mg #30, and Aciphex 20mg #30.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Norco 10/325mg #90:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Chapter, Opioids.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids, criteria for use.

**Decision rationale:** Per the MTUS, opioids should be discontinued if there is no overall improvement in function, unless there are extenuating circumstances, Opioids should be continued if the patient has returned to work or has improved functioning and pain. On going management actions should include 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. Documentation should follow the 4 A's of analgesia, activities of daily living, adverse side effects, and aberrant drug taking behaviors. Long-term users of opioids should be regularly reassessed. In the maintenance phase, the dose should not be lowered if it is working. Also, patients who receive opioid therapy may sometimes develop unexpected changes in their response to opioids, which includes development of abnormal pain, change in pain pattern, persistence of pain at higher levels than expected when this happens opioids can actually increase rather than decrease sensitivity to noxious stimuli it is important to note that a decrease in opioid efficacy should not always be treated by increasing the dose or adding other opioids, but may actually require weaning. A review of the injured workers medical records do not reveal documentation of pain and functional improvement as well as ongoing management actions as required by the guidelines, without this information it is not possible to establish medical necessity, therefore the request for Norco is not medically necessary.

**Lorazepam 1mg #60:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Chapter, Mental Illness and Stress, Benzodiazepines.

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

**Decision rationale:** The MTUS does not recommend long-term use of benzodiazepines, long-term efficacy is unproven and there is a risk of dependence most guidelines limit use to 4 weeks tolerance to all of its effects develop within weeks to months, and long term use may actually increase anxiety, a more appropriate treatment for anxiety disorder is an antidepressant. Chronic benzodiazepines are the treatment of choice in very few conditions. A review of the injured workers medical records do not reveal extenuating circumstances that would warrant deviating from the guidelines and therefore the request for lorazepam is not medically necessary.

### **Celebrex 200mg #30: Overturned**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Chapter, NSAIDs, GI symptoms and cardiovascular risk, Anti-inflammatory medications.

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

**Decision rationale:** Per the MTUS, NSAIDs and COX-2 NSAIDs are recommended at the lowest dose for the shortest period in patients with moderate to severe pain. Acetaminophen may be considered for initial therapy for patients with mild to moderate pain, and in particular, for those with gastrointestinal, cardiovascular or renovascular risk factors. NSAIDs appear to be superior to acetaminophen, particularly for patients with moderate to severe pain. There is no evidence to recommend one drug in this class over another based on efficacy. In particular, there appears to be no difference between traditional NSAIDs and COX-2 NSAIDs in terms of pain relief. The main concern of selection is based on adverse effects. COX-2 NSAIDs have fewer GI side effects at the risk of increased cardiovascular side effects, although the FDA has concluded that long-term clinical trials are best interpreted to suggest that cardiovascular risk occurs with all NSAIDs and is a class effect (with naproxen being the safest drug). There is no evidence of long-term effectiveness for pain or function. (Chen, 2008) (Laine, 2008) Clinicians should weigh the indications for NSAIDs against both GI and cardiovascular risk factors according to specific criteria listed in the MTUS and a selection should be made based on this. A review of the injured workers medical records reveal that he is at increased risk for a gastrointestinal event based on his age and the use of Celebrex is appropriate for managing this injured workers moderate pain. Therefore, the request for Celebrex 200mg #30 is medically necessary.

### **AcipHex 20mg #30: Overturned**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Chapter, Proton pump inhibitors (PPIs).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): NSAIDs, GI symptoms & cardiovascular risk. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain (Chronic) / Proton Pump Inhibitors (PPIs).

**Decision rationale:** Per the MTUS, Clinicians should weigh the indications for NSAIDs against both GI and cardiovascular risk factors according to specific criteria listed in the MTUS and a selection should be made based on these criteria (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). Per the ODG, PPI's are recommended for patients at risk for gastrointestinal events. Prilosec (omeprazole), Prevacid (lansoprazole) and Nexium (esomeprazole magnesium) are PPIs. Healing doses of PPIs are more effective than all other therapies, although there is an increase in overall adverse effects compared to placebo. Nexium and Prilosec are very similar molecules. (Donnellan, 2010) In this RCT omeprazole provided a statistically significantly greater acid control than lansoprazole. (Miner, 2010) In general, the use of a PPI should be limited to the recognized indications and

used at the lowest dose for the shortest possible amount of time. PPIs are highly effective for their approved indications, including preventing gastric ulcers induced by NSAIDs. Studies suggest, however, that nearly half of all PPI prescriptions are used for unapproved indications or no indications at all. Many prescribers believe that this class of drugs is innocuous, but much information is available to demonstrate otherwise. Products in this drug class have demonstrated equivalent clinical efficacy and safety at comparable doses, including esomeprazole (Nexium), lansoprazole (Prevacid), omeprazole (Prilosec), pantoprazole (Protonix), dexlansoprazole (Dexilant), and rabeprazole (Aciphex). (Shi, 2008) A trial of omeprazole or lansoprazole had been recommended before prescription Nexium therapy (before it went OTC). The other PPIs, Protonix, Dexilant, and Aciphex, should be second-line. According to the latest AHRQ Comparative Effectiveness Research, all of the commercially available PPIs appeared to be similarly effective. (AHRQ, 2011). A review of the injured workers medical records that are available to me reveal that he is at increased risk for gastrointestinal event due to his age, therefore the request for aciphex 20 mg #30 is medically necessary.