MAXIMUS Federal Services

Case Number:	CM15-0191003		
Date Assigned:	10/05/2015	Date of Injury:	10/07/2008
Decision Date:	12/03/2015	UR Denial Date:	08/27/2015
Priority:	Standard	Application Received:	09/28/2015

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: Family Practice

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 52 year old female, who sustained an industrial injury on 10-07-2008. The injured worker was diagnosed as having carpal tunnel syndrome, myalgia and myositis, unspecified, lumbar spondylosis without myelopathy, and cervical spondylosis without myelopathy. A history of depressive disorder was documented. Treatment to date has included diagnostics, chiropractic, physical therapy, hand-wrist splints, mental health treatment, and medications. On 7-24-2015, the injured worker complains of "increased bilateral wrist pain" and reported that her neck and lower back pain "has gotten worse". She reported that neck pain was a frequent issue and complained of tenderness, stiffness, and weakness, especially in the left side of her neck. She described numbness in both hands, worse on the left, and low back pain with radiation down both legs, worse on the left, through the buttocks and down. She reported having her Norco filled by her primary care physician. Her pain was not rated currently. Gastrointestinal complaints were not reported. She was not working and her work status was temporarily totally disabled. Electromyogram and nerve conduction studies (6-23-2015) of the upper extremities showed increased distal latency on the right median sensory fibers and evidence of right carpal tunnel syndrome. Exam of the cervical spine noted "slight decreased extension with discomfort posteriorly" and "slight decreased range of motion of the lateral flexion bilaterally and there is 1+ tenderness in the left trapezius". The left hand was "slightly hyper-reactive to light touch" over the dorsum of the hand and the right hand had "minimal tenderness" over the median nerve at the palm. Grip strength was 3+ bilaterally and she complained of pain and increased tingling

with Phalen's testing. Exam of the lumbar spine noted a lumbar brace and guarding with range of motion. She was prescribed Norco, Flexeril, Celebrex, and Omeprazole. The duration of current medication regimen could not be determined but the use of Norco and Flexeril was noted since at least 5-29-2015, along with Omeprazole since at least 6-17-2015 (psychiatric progress report). Urine toxicology and opioid contract were not referenced or submitted. Per the Request for Authorization dated 8-20-2015, the treatment plan included Celecoxib 200mg daily #30 with 1 refill, Omeprazole 200mg daily #30 with 1 refill, Norco 10-325mg every 6-8 hours as needed for pain #60, and Flexeril 10mg at bedtime #30. On 8-27-2015, Utilization Review non-certified the requested medications.

IMR ISSUES, DECISIONS AND RATIONALES

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

Celecoxib 200 mg Qty 30 with 1 refill, 1 daily: 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 (non-steroidal anti-inflammatory drugs).

Decision rationale: The MTUS/Chronic Pain Medical Treatment guidelines comment on the use of NSAIDS, including Celecoxib; also known as Celebrex. In general, these guidelines indicate that NSAIDs should be used at the lowest does for the shortest period of time. Specific recommendations on NSAIDs include the following: Osteoarthritis (including knee and hip): 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 naproxyn being the safest drug). There is no evidence of long-term effectiveness for pain or function. In patients with chronic low back pain with sciatica a recent Cochrane review (including three heterogeneous randomized controlled trials) found no differences in treatment with NSAIDs vs. placebo. In patients with axial low back pain this same review found that NSAIDs were not more effective than acetaminophen for acute low-back pain, and that acetaminophen had fewer side effects. Back Pain - Chronic low back pain: Recommended as an option for short-term symptomatic relief. A Cochrane review of the literature on drug relief for low back pain (LBP) suggested that NSAIDs were no more effective than other drugs such as acetaminophen, narcotic analgesics, and muscle relaxants. The review also found that NSAIDs had more adverse effects than placebo and acetaminophen but fewer effects than muscle relaxants and narcotic analgesics. In addition, evidence from the review suggested that no one NSAID, including COX-2 inhibitors,

was clearly more effective than another. Neuropathic pain: There is inconsistent evidence for the use of these medications to treat long- term neuropathic pain, but they may be useful to treat breakthrough and mixed pain conditions such as osteoarthritis (and other nociceptive pain) in with neuropathic pain. In this case, the records indicate that Celecoxib is being used as a long-term treatment strategy for this patient's symptoms. Only short-term use is recommended as indicated in these above cited guidelines. There is no evidence in the medical records to indicate that long-term use has been associated with objective improvement in functional outcomes. For this reason, Celecoxib is not medically necessary.

Omeprazole 200 mg Qty 30 with 1 refill, 1 daily: 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 MTUS/Chronic Pain Medical Treatment guidelines comment on the use of proton pump inhibitors (PPIs), including omeprazole, as a treatment modality. In general, PPIs are used to address the potential side effects associated with NSAIDs. The guidelines state that clinicians should weight the indications for NSAIDs against gastrointestinal (GI) risk factors. Specifically, to 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, cortico-steroids, and/or an anticoagulant; or (4) high dose/multiple NSAID (e.g., NSAID + low-dose ASA). In this case, there is no evidence that the patient is at risk for any of the above cited GI events; peptic ulcer or GI bleeding or perforation. The patient is under 65 years of age and has no documented history of ulcer or GI bleeding. Further, there is no evidence of high dose NSAIDs or use of an anticoagulant. For these reasons, omeprazole is not medically necessary.

Flexeril 10 mg Qty 30, 1 every night: 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): Cyclobenzaprine (Flexeril).

Decision rationale: The MTUS/Chronic Pain Medical Treatment guidelines comment on the use of Flexeril as a treatment modality. Flexeril is recommended as an option, using a short course of therapy. 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. In this case the records indicate that Flexeril is being used as a long-term treatment strategy for this patient. Only short-term use is recommended. There is no evidence that long-term use in this patient is associated with improved objective outcomes. For these reasons, Flexeril is not medically necessary.

Norco 10/325 mg Qty 60, 1 by mouth every 6-8 hrs as needed: 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): Opioids, criteria for use, Opioids for chronic pain, Opioids, dealing with misuse & addiction, Opioids, indicators for addiction, Opioids, long-term assessment, Opioids, pain treatment agreement.

Decision rationale: The MTUS/Chronic Pain Medical Treatment Guidelines comment on the long-term use of opioids, including Norco. These guidelines have established criteria of the use of opioids for the ongoing management of pain. Actions should include: prescriptions from a single practitioner and from a single pharmacy. The lowest possible dose should be prescribed to improve pain and function. There should be an 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 patient's decreased pain, increased level of function, or improved quality of life. There should be evidence of documentation of the 4 As for Ongoing Monitoring. These four domains include: pain relief, side effects, physical and psychological functioning, and the occurrence of any potentially aberrant drug-related behaviors. Further, there should be 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 that does not improve on opioids in 3 months. There should be consideration of an addiction medicine consult if there is evidence of substance misuse (Pages 76-78). Finally, the guidelines indicate that for chronic pain, the long-term efficacy of opioids is unclear. Failure to respond to a time-limited course of opioids has led to the suggestion of reassessment and consideration of alternative therapy (Page 80). Based on the review of the medical records, there is insufficient documentation in support of these stated MTUS/Chronic Pain Medical Treatment Guidelines for the ongoing use of opioids. There is insufficient documentation of the 4 As for Ongoing Monitoring. The treatment course of opioids in this patient has extended well beyond the timeframe required for a reassessment of therapy. In summary, there is insufficient documentation to support the chronic use of an opioid in this patient. Ongoing treatment with Norco is not considered as medically necessary.