MAXIMUS Federal Services

Case Number:	CM15-0031019		
Date Assigned:	02/24/2015	Date of Injury:	04/23/1990
Decision Date:	04/10/2015	UR Denial Date:	01/22/2015
Priority:	Standard	Application Received:	02/19/2015

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: Pennsylvania
Certification(s)/Specialty: Internal 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 52 year old female with a date of injury from 4/23/90 to November 25, 2008 due to continuous trauma. The diagnoses have included bilateral shoulder impingement syndrome with superior labral tears, rule out rotator cuff pathology, lumbar discopathy/facet arthropathy, lumbago, lumbosacral radiculitis, right elbow lateral and medial epicondylitis, cervicalgia and cervical discopathy with right upper extremity radiculitis. She has reported chronic pain with pain in the neck, low back and right shoulder. Treatment/diagnostics to date has included radiographic imaging/magnetic resonance imaging, electrodiagnostics, physical therapy, cervical and lumbar epidural steroid injection, surgery, pain medications and work restrictions. Surgery has included C5-C7 anterior cervical discectomy with subsequent removal of cervical hardware. Currently, the injured worker complains of neck pain, bilateral shoulder pain, low back pain, right elbow pain. Examination in December 2014 shows paravertebral muscle tenderness and spasm in the cervical and lumbar spine, with tingling and numbness in the lateral thigh and anterolateral leg and foot, with decreased strength in L4 innervated muscle. It was noted that medications are helping to improve the injured worker's symptoms, improving activities of daily living, and making it possible for him to continue working. Work status was noted as modified work. Medications in January 2015 include fenoprofen, omeprazole, cyclobenzaprine, tramadol, and eszopiclone. Cyclobenzaprine has been prescribed since 2012 and prior to that time, other muscle relaxants were prescribed. Tramadol has been prescribed since at least December 2013. Nonsteroidal anti-inflammatory agents (NSAIDS) and omeprazole have been prescribed for at least three years. On January 22, 2015, Utilization Review non-

certified requests for Omeprazole 20mg #120 and cyclobenzaprine 7.5mg #120, tramadol ER 150mg #90, and eszopiclone 1mg #30, citing the MTUS and ODG. This decision was subsequently appealed to Independent Medical Review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Omeprazole 20mg #120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Proton Pump Inhibitors (PPIs), NSAIDs, GI symptoms & cardiovascular risk.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS, GI symptoms and cardiovascular risk Page(s): 68.

Decision rationale: The injured worker has been prescribed NSAIDS and omeprazole for years. Per the MTUS, co-therapy with a nonsteroidal anti-inflammatory medication (NSAID) and a proton pump inhibitor (PPI) is not indicated in patients other than those at intermediate or high risk for gastrointestinal events (including age > 65 years, history of peptic ulcer, gastrointestinal (GI) bleeding or perforation, concurrent use of aspirin, corticosteroids and/or an anticoagulant, or high dose/multiple NSAIDS such as NSAID plus low dose aspirin). Long term proton pump inhibitor (PPI) use (> 1 year) has been shown to increase the risk of hip fracture. There was no documentation of any of the risk factors noted above. No GI signs and symptoms were discussed. No examination of the abdomen was documented. Due to lack of indication as well as potential for toxicity, the request for omeprazole is not medically necessary.

Cyclobenzaprine 7.5mg #120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Cyclobenzaprine (Flexeril, Amrix, Fexmid, generic available).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines cyclobenzaprine p. 41-42muscle relaxants p. 63-66 Page(s): 41-42, 63-66.

Decision rationale: The MTUS for chronic pain does not recommend muscle relaxants for chronic pain. Non-sedating muscle relaxants are an option for short-term exacerbations of chronic low back pain. The muscle relaxant prescribed in this case is sedating. The injured worker has chronic pain with no evidence of prescribing for flare-ups. The quantity prescribed implies long term use, not for a short period of use for acute pain. The injured worker has been prescribed muscle relaxants for years including cyclobenzaprine since 2012. No reports show any specific and significant improvement in pain or function as a result of prescribing muscle relaxants. Per the MTUS chronic pain medical treatment guidelines, cyclobenzaprine (Flexeril, fexmid) is a skeletal muscle relaxant and a central nervous system depressant. It is recommended as an option for a short course of therapy, with greatest effect in the first four days of treatment. Guidelines state that treatment should be brief. The addition of cyclobenzaprine to other agents is not recommended. Limited, mixed evidence does not allow for a recommendation for chronic use. Cyclobenzaprine, per the MTUS, is indicated for short term use only and is not

recommended in combination with other agents. This injured worker has been prescribed multiple medications along with cyclobenzaprine. Due to duration of use in excess of the guidelines, the request for cyclobenzaprine is not medically necessary.

Tramadol ER 150mg #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Tramadol (Ultram; Ultram ER; generic available in immediate tablet); Opioids.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines opioids Page(s): p. 74-96.

Decision rationale: Tramadol is a centrally acting synthetic opioid analgesic which is not recommended as a first line oral analgesic. Multiple side effects have been reported including increased risk of seizure especially in patients taking selective serotonin reuptake inhibitors (SSRIs), tricyclic antidepressants (TCAs) and other opioids. It may also produce life-threatening serotonin syndrome. There is no evidence that the treating physician is prescribing opioids according to the MTUS, which recommends prescribing according to function, with specific functional goals, return to work, random drug testing, and opioid contract. There should be a prior failure of non-opioid therapy. None of these aspects of prescribing are in evidence. Tramadol has been prescribed for more than one year and prior to that time other opioids were prescribed. Per the MTUS, opioids are minimally indicated, if at all, for chronic non-specific pain, osteoarthritis, 'mechanical and compressive etiologies,' and chronic back pain. There is no evidence of significant pain relief or increased function from the opioids used to date. Improvement in activities of daily living were noted without discussion of the specific activities, and there was no documentation of improvement as a result of any specific medication. There has not been a decrease in work restrictions or decrease in medication use, and office visits have continued at the same frequency. The prescribing physician does not specifically address function with respect to prescribing opioids, and does not address the other recommendations in the MTUS. The MTUS states that a therapeutic trial of opioids should not be employed until the patient has failed a trial of non-opioid analgesics. There is no evidence that the treating physician has utilized a treatment plan NOT using opioids, and that the patient "has failed a trial of non-opioid analgesics." Ongoing management should reflect four domains of monitoring, including analgesia, activities of daily living, adverse side effects, and aberrant drug-taking behaviors. The documentation does not reflect improvement in pain. Change in activities of daily living, discussion of adverse side effects, and screening for aberrant drug-taking behaviors were not documented. The MTUS recommends urine drug screens for patients with poor pain control and to help manage patients at risk of abuse. There is no record of a urine drug screen program performed according to quality criteria in the MTUS and other guidelines. As currently prescribed, tramadol does not meet the criteria for long term opioids as elaborated in the MTUS and is therefore not medically necessary.

Eszopiclone 1mg #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Eszopicolone (Lunesta). Decision based on Non-MTUS Citation Official Disability guidelines, Mental Illness & Stress.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) chronic pain chapter: insomnia treatment.

Decision rationale: Lunesta (eszopiclone) is a nonbenzodizepine hypnotic agent indicated for the treatment of insomnia. The MTUS does not address the use of hypnotics other than benzodiazepines. No physician reports describe the specific criteria for a sleep disorder. Treatment of a sleep disorder, including prescribing hypnotics, should not be initiated without a careful diagnosis. There is no evidence of that in this case. For the treatment of insomnia, pharmacologic agents should only be used after careful evaluation of potential causes of sleep disturbance. Specific components of insomnia should be addressed. There was no documentation of evaluation of sleep disturbance in the injured worker, and components insomnia were not addressed. The treating physician has not addressed major issues affecting sleep in this patient, including the use of other psychoactive agents like opioids, which significantly impair sleep architecture, and depression. Due to lack of sufficient evaluation for sleep disorder, the request for eszopiclone is not medically necessary.