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| Case Number: | CM15-0036897 | | |
| Date Assigned: | 03/05/2015 | Date of Injury: | 03/12/2001 |
| Decision Date: | 04/20/2015 | UR Denial Date: | 02/04/2015 |
| Priority: | Standard | Application Received: | 02/26/2015 |

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 43 year old male who sustained an industrial related injury on 7/31/02. The injured worker had complaints of right lower extremity numbness and pain. Tingling in the legs, bilateral burning flank pain, neck stiffness, and numbness in the hands and forearms were also noted. Physical examination findings included spasms in the lumbar and thoracic spine. Sensation was decreased in the posterior thigh and straight leg raise tests were positive bilaterally. Diagnoses included lumbar spine radiculitis, chronic headaches, and herniated nucleus pulposus at L4-5 and L5-S1. Medications included Vicodin, Voltaren, and Robaxin.

IMR ISSUES, DECISIONS AND RATIONALES

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

Methocarbamol 750mg #30: Overturned

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 Muscle relaxants (for pain) Page(s): 63-65. Decision based on Non-MTUS Citation Physicians Desk Reference (PDR)/ Robaxin (methocarbamol).

Decision rationale: The MTUS describes methocarbamol as an antispasmodic whose mechanism of action is not known but appears to be related to central nervous system depressant effects with related sedative properties. Per the PDR methocarbamol is a centrally acting muscular analgesic, indicated as an adjunct for relief of acute, painful musculoskeletal conditions. The MTUS recommends non-sedating muscle relaxants with caution as a second-line option for short-term (less than two weeks) treatment of acute LBP and for short-term treatment of acute exacerbations in patients with chronic LBP. Muscle relaxants may be effective in reducing pain and muscle tension, and increasing mobility. However, in most LBP cases, they show no benefit beyond NSAIDs in pain and overall improvement. Also, there is no additional benefit shown in combination with NSAIDs. Efficacy appears to diminish over time, and prolonged use of some medications in this class may lead to dependence. Sedation is the most commonly reported adverse effect of muscle relaxant medications. These drugs should be used with caution in patients driving motor vehicles or operating heavy machinery. Drugs with the most limited published evidence in terms of clinical effectiveness include chlorzoxazone, methocarbamol, dantrolene and baclofen. According to a recent review in American Family Physician, skeletal muscle relaxants are the most widely prescribed drug class for musculoskeletal conditions (18.5% of prescriptions), and the most commonly prescribed antispasmodic agents are carisoprodol, cyclobenzaprine, metaxalone, and methocarbamol, but despite their popularity, skeletal muscle relaxants should not be the primary drug class of choice for musculoskeletal conditions. However, the injured worker appears to be benefiting from the use of this medication and is medically necessary.

Robaxin 750mg: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain) Page(s): 63-65. Decision based on Non-MTUS Citation Physicians Desk Reference (PDR)/ Robaxin (methocarbamol).

Decision rationale: The MTUS describes methocarbamol as an antispasmodic whose mechanism of action is not known but appears to be related to central nervous system depressant effects with related sedative properties. Per the PDR methocarbamol is a centrally acting muscular analgesic, indicated as an adjunct for relief of acute, painful musculoskeletal conditions. The MTUS recommends non-sedating muscle relaxants with caution as a second-line option for short-term (less than two weeks) treatment of acute LBP and for short-term treatment of acute exacerbations in patients with chronic LBP. Muscle relaxants may be effective in reducing pain and muscle tension, and increasing mobility. However, in most LBP cases, they show no benefit beyond NSAIDs in pain and overall improvement. Also, there is no additional benefit shown in combination with NSAIDs. Efficacy appears to diminish over time, and prolonged use of some medications in this class may lead to dependence. Sedation is the most commonly reported adverse effect of muscle relaxant medications. These drugs should be used with caution in patients driving motor vehicles or operating heavy machinery. Drugs with the most limited published evidence in terms of clinical effectiveness include chlorzoxazone,

methocarbamol, dantrolene and baclofen. According to a recent review in American Family Physician, skeletal muscle relaxants are the most widely prescribed drug class for musculoskeletal conditions (18.5% of prescriptions), and the most commonly prescribed antispasmodic agents are carisoprodol, cyclobenzaprine, metaxalone, and methocarbamol, but despite their popularity, skeletal muscle relaxants should not be the primary drug class of choice for musculoskeletal conditions. However, the injured worker appears to be benefiting from the use of methocarbamol which has been deemed medically necessary in a separate request this appears to be a duplicate request for the same medication and therefore this request for robaxin 750 mg is not medically necessary.

Norco 10/325mg #30: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Hydrocodone/Acetaminophen.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74-96 (78, 95).

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. Ongoing management 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. 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, and 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 show documented partial improvement in functioning and pain and per the medical records aberrant drug taking behaviors have been addressed. Therefore based on the injured workers clinical presentation and the guidelines the request for Norco 10/325mg #30 is medically necessary.

Prilosec 20mg: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS, GI symptoms & cardiovascular risk.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS, GI symptoms and cardiovascular risk Page(s): 68-69. 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, PPIs 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 do not show that this injured worker is at increased risk for gastrointestinal events and therefore the request for Prilosec 20mg is not medically necessary.

One urine drug screen: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Urine Drug Testing (UDT), Opioids - Criteria for Use. Decision based on Non-MTUS Citation Official Disability Guidelines, Pain (Chronic), Opioids, tools for risk stratification & monitoring.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Drug testing Page(s): 43. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain (Chronic) / Urine drug screen.

Decision rationale: Per the MTUS, Drug testing is recommended as an option, using a urine drug screen to assess for the use or the presence of illegal drugs, however the MTUS did not address frequency of drug testing therefore other guidelines were consulted. Per the ODG Urine drug testing is recommended as a tool to monitor compliance with prescribed substances, identify use of undisclosed substances, and uncover diversion of prescribed substances. The test should be used in conjunction with other clinical information when decisions are to be made to continue, adjust or discontinue treatment. This information includes clinical observation, results of addiction screening, pill counts, and prescription drug monitoring reports. The prescribing clinician should also pay close attention to information provided by family members, other providers and pharmacy personnel. The frequency of urine drug testing may be dictated by state and local laws. Frequency of urine drug testing should be based on documented evidence of risk stratification including use of a testing instrument. Patients at low risk of addiction/aberrant behavior should be tested within six months of initiation of therapy and on a yearly basis thereafter. There is no reason to perform confirmatory testing unless the test is inappropriate or

there are unexpected results. If required, confirmatory testing should be for the questioned drugs only. Patients at moderate risk for addiction/aberrant behavior are recommended for point-of-contact screening 2 to 3 times a year with confirmatory testing for inappropriate or unexplained results. This includes patients undergoing prescribed opioid changes without success, patients with a stable addiction disorder, those patients in unstable and/or dysfunction social situations, and for those patients with co-morbid psychiatric pathology. Patients at high risk of adverse outcomes may require testing as often as once per month. This category generally includes individuals with active substance abuse disorders. A review of the injured workers medical records that are available to me reveals that a urine drug screen is medically necessary and appropriate in this injured worker.