

Case Number:	CM15-0046240		
Date Assigned:	03/18/2015	Date of Injury:	01/27/2009
Decision Date:	05/12/2015	UR Denial Date:	02/19/2015
Priority:	Standard	Application Received:	03/11/2015

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 58 year old male who sustained a work related injury January 27, 2009. According to a primary treating physician's progress report dated January 29, 2015, the injured worker presented for evaluation of persistent low back pain with radicular symptoms into his lower extremity as well as his bilateral knee pain. He has had an epidural injection which only gave relief for a couple of weeks, Butrans helps but gets denied often and Norco is helping manage the pain form an 8/10 to a 3/10. He is able to perform household chores such as; laundry, dishes, and vacuuming, but is currently not working. Diagnoses included chronic low back pain with MRI revealing multiple disk protrusions and spinal stenosis; chronic left knee pain with MRI revealing degenerative arthropathy; s/p left shoulder arthroscopic surgery February, 2012; s/p right shoulder arthroscopic surgery August, 2010, s/p left inguinal hernia repair March, 2009; s/p Synvisc injection x 3 August, 2009; depression and anxiety due to chronic pain. Treatment plan included requests for medication, physical therapy, prescription for medications, and a urine drug screen performed, which was consistent.

IMR ISSUES, DECISIONS AND RATIONALES

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

Botox 400 units low back muscles: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation FDA Announcement (www.fda.gov/NewsEvents/Newsroom/PressAnnouncements/ucm229782.htm); FDA NEWS RELEASE, For Immediate Release: Oct. 15, 2010.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Botulinum toxin Page(s): 25-26.

Decision rationale: Per the MTUS, Botulinum toxin is "recommended for chronic low back pain, if a favorable initial response predicts subsequent responsiveness, as an option in conjunction with a functional restoration program. Some additional new data suggests that it may be effective for low back pain. (Jabbari, 2006) (Ney,2006) Botulinum neurotoxin may be considered for low back pain (Level C). (Naumann, 2008)". A review of the injured workers medical records reveals that he has had persistent low back pain that is partially responsive to opioid therapy and it is being used together with physical therapy as part of a functional restoration program. Based on the clinical indication and the guidelines the request for Botox 400 units low back muscles is medically necessary and appropriate.

Physical therapy times 8: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99.

Decision rationale: Per the MTUS, physical therapy is recommended following specific guidelines, allowing for fading of treatment frequency from up to 3 visits per week to 1 or less, plus active self directed home physical medicine. For myalgia and myositis unspecified the guidelines recommend 9-10 visits over 8 weeks. Neuralgia, neuritis and radiculitis unspecified 8-10 visits over 4 weeks. A review of the injured workers medical records reveal that the request is part of a functional restoration program, is within the guideline recommendations and is medically necessary.

Urine drug screen: Overturned

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Drug testing Page(s): 43.

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, before starting opioids and during ongoing management and maintenance to ensure compliance with treatment and to detect misuse, addiction or the use of non prescribed medications, the injured workers has already

reported receiving Norco from a friend which is aberrant drug taking behavior, therefore the request for urine drug screen is medically necessary in the injured worker.

Norco 10/325mg #60: Overturned

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74-96 (78,89,95).

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 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 reveal documentation according to guideline recommendations of his pain and functional improvement with the use of Norco and therefore the request for Norco 10/325mg #60 is medically necessary.

Prilosec 20mg #60 (3 refills): Overturned

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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, 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 has a history of gastrointestinal irritation due to NSAID use and the continued use of Prilosec 20mg # 60 with 3 refills is medically necessary.