

<b>Case Number:</b>	CM14-0145927		
<b>Date Assigned:</b>	09/12/2014	<b>Date of Injury:</b>	11/19/2012
<b>Decision Date:</b>	11/26/2014	<b>UR Denial Date:</b>	08/07/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/08/2014

### 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. The expert reviewer is Board Certified in Emergency Medicine and is licensed to practice in New York. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### 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 patient is a 48-year-old female who was injured on November 19, 2012. The patient continued to experience pain in her neck, and low back. Physical examination was notable for tenderness over the lumbar paraspinal muscles, limited range of motion of the cervical and lumbar spine, cervical spinal vertebral tenderness at C5-7, myofascial trigger points in the right trapezius muscles, and decreased sensation in the right C6 dermatome and right L4 dermatome. Diagnoses included cervical radiculopathy, lumbar radiculopathy, and right shoulder pain. Treatment included aqua therapy and medications. Requests for authorization for Butrans patch 10 mcg #4, Cyclobenzaprine, 10 mg #90, Hydrocodone 10/325 mg #60, and Omeprazole 20 mg #60 were submitted for consideration.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Butran Patch 10mcg #4:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 26-27.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Pain Interventions Page(s): 26-27. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Buprenorphine

**Decision rationale:** Butran is Buprenorphine, a semi-synthetic opioid partial agonist and a kappa receptor antagonist. It is recommended as an option for treatment of chronic pain (consensus based) in selected patients (not first-line for all patients). Suggested populations: (1) Patients with a hyperalgesic component to pain; (2) Patients with centrally mediated pain; (3) Patients with neuropathic pain; (4) Patients at high-risk of non-adherence with standard opioid maintenance; (5) For analgesia in patients who have previously been detoxified from other high-dose opioids. Use for pain with formulations other than Butrans is off-label. Due to complexity of induction and treatment, the drug should be reserved for use by clinicians with experience. In this case, the documentation in the medical record does not support that the patient is one of the selected patients at listed above. There is no indication for the use of butran. The request should not be authorized.

**Cyclobenzaprine 10mg #90:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 64.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Pain Interventions Page(s): 63.

**Decision rationale:** Cyclobenzaprine is a muscle relaxant. Cyclobenzaprine is recommended as an option, for a short course of therapy. It has been found to be more effective than placebo with greater adverse side effects. Its greatest effect is in the first 4 days. Treatment should be brief. Non-sedating muscle relaxants are recommended with caution as a second-line option for short-term treatment (less than two weeks) 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. In addition, 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. In this case, the patient had been using muscle relaxants since at least March 2013. The duration of treatment surpasses the recommended short-term duration of two weeks. The request should not be authorized.

**Hydrocodone 10/325mg #60:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 91.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Pain Interventions Page(s): 11, 74-96.

**Decision rationale:** Hydrocodone 10/325 is the compounded medication containing Hydrocodone and Acetaminophen. Chronic Pain Medical Treatment Guidelines state that opioids are not recommended as a first line therapy. Opioid should be part of a treatment plan specific

for the patient and should follow criteria for use. Criteria for use include establishment of a treatment plan, determination if pain is nociceptive or neuropathic, failure of pain relief with non-opioid analgesics, setting of specific functional goals, and opioid contract with agreement for random drug testing. If analgesia is not obtained, opioids should be discontinued. The patient should be screened for likelihood that he or she could be weaned from the opioids if there is no improvement in pain or function. It is recommended for short-term use if first-line options, such as Acetaminophen or NSAIDs have failed. Opioids may be a safer choice for patients with cardiac and renal disease than antidepressants or anticonvulsants. Acetaminophen is recommended for treatment of chronic pain & acute exacerbations of chronic pain. Acetaminophen overdose is a well-known cause of acute liver failure. Hepatotoxicity from therapeutic doses is unusual. Renal insufficiency occurs in 1 to 2% of patients with overdose. The recommended dose for mild to moderate pain is 650 to 1000 mg orally every 4 hours with a maximum of 4 g/day. In this case, the patient had been taking opioid medication since at least March 2013 and had not obtained analgesia. In addition, there is no documentation that the patient has signed an opioid contract or is participating in urine drug testing. Criteria for long-term opioid use have not been met. The request should not be authorized.

**Omeprazole DR 20mg #60:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines 68-69.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Pain Interventions Page(s): 68.

**Decision rationale:** Omeprazole is a Proton Pump Inhibitor (PPI). PPI's are used in the treatment of peptic ulcer disease and may be prescribed in patients who are using non-steroidal anti-inflammatory drugs and are at high risk for gastrointestinal events. Risk factors for high-risk events are age greater than 65, history of peptic ulcer, GI bleeding or perforation, concurrent use of ASA, corticosteroids, and/or an anticoagulant, or high dose/multiple NSAID (e.g., NSAID + low-dose ASA). The patient in this case was not using NSAID medication and did not have any of the risk factors for a gastrointestinal event. The request should not be authorized.