

<b>Case Number:</b>	CM15-0016018		
<b>Date Assigned:</b>	02/06/2015	<b>Date of Injury:</b>	10/26/2012
<b>Decision Date:</b>	03/25/2015	<b>UR Denial Date:</b>	12/30/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/28/2015

### 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 54 year old male who sustained an industrial injury reported on 10/26/2012. He has reported chronic radiating neck and low back pain, right shoulder pain, and bilateral knee pain. The diagnoses have included cervical and lumbar radiculopathy; cervical and lumbar disc with myelopathy with musculoligamentous injury; and bilateral shoulder internal derangement and musculoligamentous injury. Treatments to date have included consultations; diagnostic imaging studies; lumbar 4-5 laminectomy/discectomy (2006); right shoulder arthroscopic surgery (1999); left knee arthroscopic surgery (1997) with revision in 2004; right knee arthroscopic surgery (2002 & 2009); and medication management. The work status classification for this injured worker (IW) was noted to have reached maximum medical improvement and is back at work on modified duties for 45 days (from 1/7/15). On 12/29/2014, Utilization Review (UR) non-certified, for medical necessity, the request, made on 12/23/2014, for Norco 10/325mg, the remaining #15, for the purpose of weaning, and Prilosec 20mg #60. The Medical Treatment Utilization Schedule, chronic pain medical treatment guidelines, opioids for chronic pain, non-steroidal anti-inflammatories against gastrointestinal and cardiac risk factors, were cited. The progress notes, dated 12/15/2014, note the request for Norco 10/325mg, 1 tablet 3 times a day, #90 for which #75 were approved on a previous UR.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Prilosec 20mg #60:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI Symptoms and Cardiovascular Risk.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI Symptoms & Cardiovascular Risk Page(s): 68-69.

**Decision rationale:** The MTUS/Chronic Pain Medical Treatment Guidelines comment on the use of Proton Pump Inhibitors (PPIs), such as Prilosec as a treatment modality. The intent for the use of PPIs is to mitigate the effects of NSAID use; specifically to reduce the risk of a gastrointestinal event, e.g. GI bleeding or perforation. The MTUS guidelines state the following: Recommend with precautions as indicated below. Clinicians should weight the indications for NSAIDs against both GI and cardiovascular risk factors. 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, corticosteroids, and/or an anticoagulant; or (4) high dose/multiple NSAID (e.g., NSAID + low-dose ASA). Recent studies tend to show that H. Pylori does not act synergistically with NSAIDs to develop gastroduodenal lesions. Recommendations: Patients with no risk factor and no cardiovascular disease: Non-selective NSAIDs OK (e.g, ibuprofen, naproxen, etc.). Patients at intermediate risk for gastrointestinal events and no cardiovascular disease: (1) A non-selective NSAID with either a PPI (Proton Pump Inhibitor, for example, 20 mg omeprazole daily) or misoprostol (200g four times daily) or (2) a Cox-2 selective agent. Long-term PPI use (1 year) has been shown to increase the risk of hip fracture (adjusted odds ratio 1.44). Patients at high risk for gastrointestinal events with no cardiovascular disease: A Cox-2 selective agent plus a PPI if absolutely necessary. Patients at high risk of gastrointestinal events with cardiovascular disease: If GI risk is high the suggestion is for a low-dose Cox-2 plus low dose Aspirin (for cardioprotection) and a PPI. If cardiovascular risk is greater than GI risk the suggestion is naproxyn plus low-dose aspirin plus a PPI. In this case, based on the available information, the patient does not have any of the above stated risk factors for a gastrointestinal event. Specifically, the patient is under age 65, has no documented history of a significant GI event, and is not on an anticoagulant or additional NSAID. Therefore, for these reasons, Prilosec is not considered as medically necessary.

**Norco 10/325mg #90:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids for chronic pain Page(s): 80-81.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 76-78, 80.

**Decision rationale:** The MTUS/Chronic Pain Medical Treatment Guidelines comment on the long-term use of opioids such as Norco. These guidelines have established criteria on 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 A's 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 A's 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. Treatment with Norco is not considered as medically necessary.