

Case Number:	CM15-0171830		
Date Assigned:	09/21/2015	Date of Injury:	03/28/2008
Decision Date:	10/30/2015	UR Denial Date:	08/06/2015
Priority:	Standard	Application Received:	09/01/2015

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: Washington, California

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 42 year old female who sustained an industrial injury March 28, 2008. Diagnoses have included pseudoarthrosis; status post exploration and revision of anterior and posterior fusion. A CT cervical myelogram dated February 26, 2015 reported status post cervical fusion with mild chronic changes and perhaps minimal narrowing of the central canal at the C5-6 level; no high-grade central canal stenosis or neural foraminal stenosis suggested. Treatment has included surgery and medication. The primary treating physician note on February 10, 2015 documented that with medication her pain was 5-6/10 but without medication, it was 8-9/10. Her medication regime was: Lyrica 150 mg twice per day, Flector Patches, Percocet 5 tabs per day and Nexium 40 mg per day. She tolerated all her medications without side effects. It was noted in this medical record that the patient is very sensitive to medications; most cause nausea - Nexium helped control this symptoms. Also documented in a progress note dated May 6, 2015, was a review of bilateral upper extremity EMG (electromyography) studies which revealed evidence of mild bilateral cubital tunnel syndrome and possibly C7 and C8 nerve root damage without evidence of radial or ulnar neuropathy. According to a physician's notes dated July 29, 2015, the injured worker presented for follow-up and reported not tolerating the Butrans patch. It caused nausea and vomiting and a feeling of motion sickness. Objective findings included no significant change in physical examination; wearing a C-collar, well healed scarring in the anterior and posterior aspect of the neck; very guarded range of motion of the cervical spine with inability to extend beyond 10 degrees and flex beyond 40 degrees 40-45 degrees with complaints of pain and stiffness at the base of the neck. The motor and sensory examinations of the upper

extremities were grossly normal. Deep tendon reflexes were 0-1+ bilateral biceps, triceps and brachioradialis. The physician documents: "he has tried every medication available both short and long acting, she is very sensitive in terms of side-effects". Treatment plan included to resume Percocet as needed for flare-ups of pain; she takes up to four or five tablets per day. At issue, is the request for authorization for Flector, Nexium, and Percocet.

IMR ISSUES, DECISIONS AND RATIONALES

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

Flector 1.3# patch #60 with 2 refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS General Approaches 2004, Section(s): Initial Approaches to Treatment, and Neck and Upper Back Complaints 2004, Section(s): Initial Care, Summary, and Chronic Pain Medical Treatment 2009, Section(s): Anti-inflammatory medications, NSAIDs (non-steroidal anti-inflammatory drugs), NSAIDs, GI symptoms & cardiovascular risk, NSAIDs, hypertension and renal function, NSAIDs, specific drug list & adverse effects, Topical Analgesics. Decision based on Non-MTUS Citation Klinge SA, Sawyer GA. Effectiveness and safety of topical versus oral non-steroidal anti-inflammatory drugs: a comprehensive review. Phys Sportsmed. 2013 May; 41 (2): 64-74.

Decision rationale: Diclofenac Topical Patch (Flector Patch) is a non-steroidal anti-inflammatory (NSAID) medication indicated for topical treatment of acute pain due to minor strains, sprains & bruises and is formulated for use as a topical analgesic. Topical analgesic medications have been shown to give local analgesia. The use of topical NSAID agents to control pain is considered an option by the MTUS although it is considered largely experimental, as there is little to no research to support their use and their use is primarily recommended for osteoarthritis or chronic musculoskeletal pain. Studies on small joints and knees have shown topical NSAIDs effective in short-term use trails for chronic musculoskeletal pain. There is little evidence to recommend them to treat osteoarthritis of the spine, hip or shoulder and the MTUS does not recommend their use to treat neuropathic pain. Long-term use of topical NSAIDs has not been adequately studied. Head-to-head studies of oral NSAIDs with topical NSAIDs suggest topical preparations should be considered comparable to oral NSAIDs and are associated with fewer serious adverse events, specifically gastrointestinal reactions. This patient has neuropathic/spinal pain. Use of topical NSAIDs is not recommended by the MTUS. Medical necessity for continued use of Flector Patch has not been established, therefore is not medically necessary.

Nexium 40mg #30 with 2 refills: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): NSAIDs, GI symptoms & cardiovascular risk.

Decision rationale: Esomeprazole is classified as a proton pump inhibitor and recommended for treatment of dyspepsia, peptic ulcer disease, gastroesophageal reflux disease, laryngopharyngeal reflux, and Zollinger Ellison syndrome. The MTUS recommends its use to prevent dyspepsia or peptic ulcer disease secondary to longer term use of non-steroidal anti-inflammatory drugs (NSAIDs) in patients that are at intermediate risk of developing gastric problems from the NSAIDs but does not address its use to prevent or treat dyspepsia caused by long term use of opioids, which is a known side effect of opioid medications. Other pain guidelines do not address the opioid-induced dyspepsia issue either. Since chronic opioid use in this patient has caused dyspepsia, she is at intermediate to high risk for this happening while on any opioid even though she appears to be tolerating her present opioid without side effects. Use of esomeprazole in this patient is an appropriate therapy. Medical necessity for use of this medication has been established, therefore is medically necessary.

Percocet 10-325mg #150 with 2 refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS General Approaches 2004, Section(s): Initial Approaches to Treatment, and Chronic Pain Medical Treatment 2009, Section(s): Medications for chronic pain, Opioids (Classification), Opioids, California Controlled Substance Utilization Review and Evaluation System (CURES) [DWC], Opioids, criteria for use, Opioids for chronic pain, Opioids for neuropathic pain, Opioids for osteoarthritis, Opioids, cancer pain vs. nonmalignant pain, Opioids, dealing with misuse & addiction, Opioids, differentiation: dependence & addiction, Opioids, dosing, Opioids, indicators for addiction,.

Decision rationale: Oxycodone/APAP (Percocet) is a combination medication made up of the semisynthetic opioid, oxycodone, and acetaminophen, better known as tylenol. It is indicated for treatment of moderate to severe pain and is available in immediate release and controlled release forms. Maximum dose according to the MTUS is limited to 4 gm of acetaminophen per day. If being used to treat neuropathic pain, then it is considered a second-line treatment (first-line are antidepressants and anticonvulsants), however, there are no long-term studies to suggest chronic use of opioids for neuropathic pain. If treating chronic low back pain, opioids effectiveness is limited to short-term pain relief (up to 16 weeks) as there is no evidence of long-term effectiveness. It is known that long-term use of opioids is associated with hyperalgesia and tolerance. According to the MTUS, opioid therapy for control of chronic pain, while not considered first line therapy, is considered a viable alternative when other modalities have been tried and failed. Success of this therapy is noted when there is significant improvement in pain or function. It is important to note, however, the maximum daily dose of opioids, calculated as morphine equivalent dosing from use of all opioid medications, is 120 mg per day. The major risks of opioid therapy are the development of addiction, overdose and death. The pain guidelines in the MTUS directly address opioid use by presenting a number of recommendations required for providers to document safe use of these medications. The provider has noted in at

least one medical record the effectiveness of this medication and lack of side effects. The present dosage of Percocet has been stable for at least 4 months and its calculated morphine equivalent dosage is 75 mg/day, which is well within the MTUS guidelines. However, the provider has not documented the required monitoring tests and assessments for the safe use of chronic opioid therapy, specifically there are no urine drug screens or medical record notations of potential abuse or drug seeking behavior. There is also no documentation that trials of other first-line medications for neuropathic pain, such as antidepressants or anti-epileptics, were attempted and failed. If stopping this medication weaning is recommended. Given all the above information, medical necessity for continued use of this medication has not been established, therefore is not medically necessary.