

Case Number:	CM15-0174389		
Date Assigned:	09/16/2015	Date of Injury:	04/23/2014
Decision Date:	11/06/2015	UR Denial Date:	08/25/2015
Priority:	Standard	Application Received:	09/04/2015

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:

This 32 year old male sustained an industrial injury on 4-23-14. Documentation indicated that the injured worker was receiving treatment for lumbar sprain and strain with disc bulges. Magnetic resonance imaging lumbar spine (10-28-14) showed multilevel disc bulges. Magnetic resonance imaging thoracic spine (3-20-15) showed mild disc desiccation and height loss of the upper to mid thoracic spine without disc protrusion or stenosis. Previous treatment consisted of medication management. In a Pr-2 dated 3-18-15, the injured worker complained of ongoing back pain with a stabbing pain below the left shoulder blade and numbness in the legs to the toes. The injured worker was having trouble driving due to increased pain. The injured worker was unable to apply the brake in his car sometimes. Physical exam was remarkable for tenderness 2 inches lateral to T8. The injured worker received a Ketorolac injection. The treatment plan included medications (Omeprazole, Methocarbamol and Norco). In a PR-2 dated 6-3-15, the injured worker complained of constant low back pain with increasing pain to both legs that radiated down to the feet associated with numbness and burning on both legs down to the feet. Physical exam was remarkable for tenderness to palpation over bilateral posterior superior iliac spine. The treatment plan included continuing medications (Norco, Methocarbamol and Omeprazole). In a PR-2 dated 8-18-15, the injured worker complained of constant low back pain with radiation down both legs. The injured worker stated he had difficulty walking due to a feeling of weakness and instability in both legs. Physical exam was remarkable for tenderness to palpation over the right posterior superior iliac spine. The injured worker received a Ketorolac injection. The treatment plan included continuing exercise, including yoga, and medications

(Norco, Methocarbamol and Omeprazole). On 8-25-15, Utilization Review noncertified a request for Methocarbamol 750mg #90, Omeprazole 20mg #30 with 5 refills, Ketorolac 60mg with lidocaine 1ml and Norco 10-325mg #60.

IMR ISSUES, DECISIONS AND RATIONALES

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

Methocarbamol 750mg #90: Upheld

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): Muscle relaxants (for pain).

Decision rationale: The MTUS recommends non-sedating muscle relaxants with caution as a second-line option 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. (Homik, 2004) 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. This medication is not recommended for long-term use and there are no extenuating circumstances or documentation of pain or functional improvement that warrant continued use in the injured worker, therefore the request for Methocarbamol is not medically necessary.

Hydrocodone-Apap 10-325mg #60: Upheld

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): Opioids, criteria for use.

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 that are available for review did not reveal documentation of improvement in pain and function with the use of this medication, neither was there documentation of ongoing management actions as required by the guidelines, without this information it is not possible to establish medical necessity, therefore the request for Hydrocodone-Apap 10-325mg #60 is not medically necessary.

Omeprazole 20mg #30 with 5 refills: Upheld

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 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 did not reveal any past or current gastrointestinal complaints that would indicate that the injured worker is at increased risk for a gastrointestinal event, therefore the request for Omeprazole 20mg #30 with 5 refills is not medically necessary.

Ketorolac 60mg with Lidocaine 1ml: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain, Injection with anaesthetics and/or steroids.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): NSAIDs (non-steroidal anti-inflammatory drugs).

Decision rationale: Per the MTUS, NSAIDs are recommended at the lowest dose for the shortest period in patients with moderate to severe pain. Acetaminophen may be considered for initial therapy for patients with mild to moderate pain, and in particular, for those with gastrointestinal, cardiovascular or renovascular risk factors. NSAIDs appear to be superior to acetaminophen, particularly for patients with moderate to severe pain. There is no evidence to recommend one drug in this class over another based on efficacy. In particular, there appears to be no difference between traditional NSAIDs and COX-2 NSAIDs in terms of pain relief. The main concern of selection is based on adverse effects. COX-2 NSAIDs have fewer GI side effects at the risk of increased cardiovascular side effects, although the FDA has concluded that long-term clinical trials are best interpreted to suggest that cardiovascular risk occurs with all NSAIDs and is a class effect (with naproxyn being the safest drug). There is no evidence of long-term effectiveness for pain or function. A review of the injured workers medical records that are available to me do not reveal a clear rationale for the choice of Ketorolac in this injured worker as opposed to other first line recommended NSAID's, without this information medical necessity is not established, therefore the request for ketorolac is not medically necessary.