

<b>Case Number:</b>	CM15-0177553		
<b>Date Assigned:</b>	09/18/2015	<b>Date of Injury:</b>	11/15/2013
<b>Decision Date:</b>	10/22/2015	<b>UR Denial Date:</b>	08/07/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/09/2015

### 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: North Carolina

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 58-year-old male, with a reported date of injury of 11/15/2013. The diagnoses include lumbar sprain with radiculopathy, lumbar spondylolisthesis, degenerative disc disease of the lumbar spine, and degenerative sacroiliac joints. Treatments and evaluation to date have included lumbar support, Ibuprofen, Prilosec (since at least 11/20/2013), Soma, Naprosyn, Norco (since at least 03-16-2015), and chiropractic treatment. The diagnostic studies to date have included x-rays of the lumbosacral spine on 11-20-2013 which showed mild scoliosis, degenerative disc disease, degenerative sacroiliac joint, and facet changes with no fracture; and an MRI of the lumbar spine on 02-18-2014 which showed diffuse degenerative disc disease, significant narrowing of the upper lumbar discs, mild segmental narrowing, minimal degenerative retrolisthesis of L2 on L3, mild foraminal narrowing at multiple levels, grade 1-2 anterolisthesis of L5 on S1 with bilateral foraminal encroachment, right foraminal disc protrusion of L4-5, and a probable right renal cyst. The medical report dated 07-28-2015 indicates that the injured worker complained of low back and leg pain. He rated the pain 8 out of 10. There were no side effects noted. The treating physician indicated that the injured worker had a signed pain agreement, and part of the agreement was random urine testing. The medical records did not include urine drug testing reports. The physical examination showed lumbar flexion at 45 degrees; lumbar extension at 15 degrees; right lateral flexion at 15 degrees; left lateral flexion at 15 degrees; bilateral rotation at 10 degrees; pain with lumbar spine range of motion testing; positive supine straight leg raise bilaterally; no tenderness to palpation over the bilateral lumbar paraspinals; no tenderness to palpation over the bilateral thoracic paraspinals; tenderness to palpation over the lumbar facet joints; and no tenderness to palpation over the bilateral sacroiliac joints. The treatment plan included Prilosec 20mg, one capsule, and two times a day, and Norco 7.5-325mg, one table twice

a day. The injured worker's work status was noted as disabled. The request for authorization was dated 07-30-2015. The treating physician requested Prilosec 20mg #60 and Norco 7.5-325mg #60. On 08-07-2015, Utilization Review (UR) non-certified the request for Prilosec 20mg #60 and Norco 7.5-325mg #60.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

#### **Prilosec 20mg #60: 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:** The California chronic pain medical treatment guidelines section on NSAID therapy states: 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. (Chen, 2008) (Laine, 2008) This medication is recommended for the shortest period of time and at the lowest dose possible. The shortest period of time is not defined in the California MTUS. The requested medication is within the maximum dosing guidelines per the California MTUS. Therefore, the request is medically necessary.

#### **Norco 7.5/325mg #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 for chronic pain.

**Decision rationale:** The California chronic pain medical treatment guidelines section on opioids states for ongoing management: On-Going Management, Actions Should Include: (a) Prescriptions from a single practitioner taken as directed and all prescriptions from a single pharmacy. (b) The lowest possible dose should be prescribed to improve pain and function. (c) Office: 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. Information from family members or other caregivers should be considered in determining the patient's response to treatment. The 4 A's for Ongoing Monitoring: Four domains have been proposed as most relevant for ongoing monitoring of chronic pain patients on opioids: pain relief, side effects, physical and psychosocial functioning, and the occurrence of any potentially aberrant (or non-adherent) drug-related behaviors. These domains have been summarized as the "4 A's" (analgesia, activities of daily living, adverse side effects, and aberrant drug taking behaviors). The monitoring of these outcomes over time should affect therapeutic decisions and provide a framework for documentation of the clinical use of these controlled drugs. (Passik, 2000)

(d) Home: To aid in pain and functioning assessment, the patient should be requested to keep a pain diary that includes entries such as pain triggers, and incidence of end-of-dose pain. It should be emphasized that using this diary will help in tailoring the opioid dose. This should not be a requirement for pain management.

(e) Use of drug screening or inpatient treatment with issues of abuse, addiction, or poor pain control.

(f) Documentation of misuse of medications (doctor-shopping, uncontrolled drug escalation, drug diversion).

(g) Continuing review of overall situation with regard to non-opioid means of pain control.

(h) 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 does not improve on opioids in 3 months. Consider a psych consult if there is evidence of depression, anxiety or irritability. Consider an addiction medicine consult if there is evidence of substance misuse.

When to Continue Opioids: (a) If the patient has returned to work. (b) If the patient has improved functioning and pain. (Washington, 2002) (Colorado, 2002) (Ontario, 2000) (VA/DoD, 2003) (Maddox-AAPM/APS, 1997) (Wisconsin, 2004) (Warfield, 2004). The long-term use of this medication class is not recommended per the California MTUS unless there documented evidence of benefit with measurable outcome measures and improvement in function. There is no documentation of significant subjective improvement in pain such as VAS scores. There is no objective measure of improvement in function or activities due to medication. Work status is not mentioned. For these reasons all the criteria set forth above of ongoing and continued used of opioids have not been met. Therefore, the request is not medically necessary.