

<b>Case Number:</b>	CM15-0073858		
<b>Date Assigned:</b>	04/23/2015	<b>Date of Injury:</b>	06/10/2010
<b>Decision Date:</b>	05/27/2015	<b>UR Denial Date:</b>	03/27/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/17/2015

### 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: Pennsylvania  
 Certification(s)/Specialty: Internal 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 42-year-old male sustained an industrial injury to the neck and back on 6/10/10. Current diagnoses include lumbar spine sprain/strain, thoracic spine sprain/strain, status post cervical fusion, and postoperative swallowing-dysphagia. Previous treatment included cervical fusion, elbow sleeve and medications. Progress notes from September 2014 to March 2015 were submitted. Reports are brief and do not include detailed examination findings. Work status in September 2014 was noted as off work/permanent and stationary. Medications in September 2014 included anaprox DS, norco, Prilosec, and flurbiprofen/lidocaine cream. Fexmid was prescribed in November 2014. Progress report of 11/29/14 documented severe neck pain, weakness, restricted range of motion, and a positive MRI showing loose hardware. A urine drug screen on 1/13/15 was inconsistent with prescribed medications, as the result was negative for hydrocodone, a prescribed medication. This result was not addressed. On 2/10/15, work status was documented as permanent and stationary, unable to work. In a PR-2 dated 3/10/15, the injured worker complained of neck and low back pain as well as throat pain and difficulty swallowing. Physical exam was remarkable for an unstable gait with weakness and paresthesia. The treatment plan included medications (Anaprox, Fexmid, Prilosec, Norco and flurbiprofen/lidocaine cream). Prilosec was noted to be prescribed for gastric irritation. Work status was noted as off work/permanent and stationary. On 3/27/15, Utilization Review non-certified requests for Prilosec 20 mg #60, anaprox DS 550 mg #60, flurbiprofen lidocaine cream, and cane, and modified requests for norco 10/325 #120 to #60, fexmid 7.5 mg #90 to #20, and urine toxicology screen to 10 panel random urine drug screen for qualitative analysis (either

through point of care testing or laboratory testing) with confirmatory laboratory testing only performed on inconsistent results x1. Utilization Review cited the MTUS and ODG.

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

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

**Norco 10/325mg #120:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines opioids Page(s): 94-96.

**Decision rationale:** This injured worker has chronic neck pain. Norco has been prescribed for more than 6 months. There is insufficient evidence that the treating physician is prescribing opioids according to the MTUS, which recommends prescribing according to function, with specific functional goals, return to work, random drug testing, and opioid contract. None of these aspects of prescribing are in evidence. Per the MTUS, opioids are minimally indicated, if at all, for chronic non-specific pain, osteoarthritis, mechanical and compressive etiologies, and chronic back pain. There is no evidence of significant pain relief or increased function from the opioids used to date. Work status remains off work/permanent and stationary, and there was no discussion of activities of daily living. The prescribing physician does not specifically address function with respect to prescribing opioids, and does not address the other recommendations in the MTUS. The MTUS states that a therapeutic trial of opioids should not be employed until the patient has failed a trial of non-opioid analgesics. There is no evidence that the treating physician has utilized a treatment plan NOT using opioids, and that the patient has failed a trial of non-opioid analgesics. Ongoing management should reflect four domains of monitoring, including analgesia, activities of daily living, adverse side effects, and aberrant drug-taking behaviors. The documentation does not reflect improvement in pain. No rating of pain severity was documented, and reports reflect continued pain. Change in activities of daily living, discussion of adverse side effects, and screening for aberrant drug-taking behaviors were not documented. The MTUS recommends urine drug screens for patients with poor pain control and to help manage patients at risk of abuse. There is no record of a urine drug screen program performed according to quality criteria in the MTUS and other guidelines. A urine drug screen from January 2015 was submitted and was inconsistent with prescribed medications, as hydrocodone was not detected; this finding was not addressed by the treating physician. As currently prescribed, norco does not meet the criteria for long term opioids as elaborated in the MTUS and is therefore not medically necessary.

**Prilosec 20mg #60:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS, GI symptoms and cardiovascular risk Page(s): 68-69.

**Decision rationale:** This injured worker has been prescribed anaprox, a nonsteroidal anti-inflammatory medication (NSAID), and prilosec, a proton pump inhibitor (PPI). Per the MTUS, co-therapy with a non-steroidal anti-inflammatory medication (NSAID) and a proton pump inhibitor (PPI) is not indicated in patients other than those at intermediate or high risk for gastrointestinal events (including age > 65 years, history of peptic ulcer, gastrointestinal (GI) bleeding or perforation, concurrent use of aspirin, corticosteroids and/or an anticoagulant, or high dose/multiple NSAIDS such as NSAID plus low dose aspirin). None of these risk factors were present for this injured worker. Long term proton pump inhibitor (PPI) use (> 1 year) has been shown to increase the risk of hip fracture. Prilosec has been prescribed for at least 6 months in this case. The prescription notes the reason for prilosec as gastric irritation, without further discussion of gastrointestinal symptoms or findings. There are no medical reports, which adequately describe signs and symptoms of possible GI (gastrointestinal) disease. There is no examination of the abdomen on record. There are many possible etiologies for GI symptoms; the available reports do not provide adequate consideration of these possibilities. Empiric treatment after minimal evaluation is not indicated. Due to lack of specific indication, the request for prilosec is not medically necessary.

**Anaprox DS 550mg #60:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS Page(s): 67-73.

**Decision rationale:** This injured worker has chronic neck pain. Anaprox has been prescribed for at least 6 months. Per the MTUS, nonsteroidal anti-inflammatory drugs (NSAIDs) are recommended as a second line treatment after acetaminophen for treatment of acute exacerbations of chronic back pain. The MTUS does not specifically reference the use of NSAIDs for long-term treatment of chronic pain in other specific body parts. NSAIDs are noted to have adverse effects including gastrointestinal side effects and increased cardiovascular risk; besides these well-documented side effects of NSAIDs, NSAIDs have been shown to possibly delay and hamper healing in all the soft tissues including muscles, ligaments, tendons, and cartilage. NSAIDs can increase blood pressure and may cause fluid retention, edema, and congestive heart failure; all NSAIDS are relatively contraindicated in patients with renal insufficiency, congestive heart failure, or volume excess. They are recommended at the lowest dose for the shortest possible period in patients with moderate to severe pain. The MTUS does not recommend chronic NSAIDs for low back pain, NSAIDs should be used for the short term only. Systemic toxicity is possible with NSAIDs. The FDA and MTUS recommend monitoring of blood tests and blood pressure. There is no evidence that the prescribing physician is adequately monitoring for toxicity as recommended by the FDA and MTUS. The treating physician is prescribing oral and transdermal NSAIDs. This is duplicative, potentially toxic, and excessive, as topical NSAIDs are absorbed systemically. There was no documentation of

functional improvement as a result of use of anaprox. Work status remains off work/permanent and stationary, and there was no discussion of activities of daily living. Due to length of use in excess of the guidelines, lack of functional improvement and potential for toxicity, the request for anaprox is not medically necessary.

**Fexmid 7.5mg #90:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation ODG-TWC Pain Procedure Summary last updated 02/23/2015.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines cyclobenzaprine p. 41-42 muscle relaxants Page(s): 41-42, 63-66.

**Decision rationale:** The MTUS for chronic pain does not recommend muscle relaxants for chronic pain. Non-sedating muscle relaxants are an option for short-term exacerbations of chronic low back pain. The muscle relaxant prescribed in this case is sedating. The injured worker has chronic pain with no evidence of prescribing for flare-ups. The quantity prescribed implies long-term use, not for a short period of use for acute pain. Fexmid has been prescribed for at least 5 months. No reports show any specific and significant improvement in pain or function as a result of prescribing muscle relaxants. Per the MTUS chronic pain medical treatment guidelines, cyclobenzaprine (Flexeril, Fexmid, Amrix) is a skeletal muscle relaxant and a central nervous system depressant. It is recommended as an option for a short course of therapy, with greatest effect in the first four days of treatment. Guidelines state that treatment should be brief. Cyclobenzaprine is not recommended to be used for longer than 2-3 weeks. The addition of cyclobenzaprine to other agents is not recommended. Multiple additional medications have been prescribed for this injured worker. Limited, mixed evidence does not allow for a recommendation for chronic use. Due to length of use not in accordance with the guidelines, and lack of functional improvement, the request for fexmid is not medically necessary.

**Flurbiprofen Lidocaine cream:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines topical analgesics Page(s): 111-113.

**Decision rationale:** Per the MTUS, topical analgesics are recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. If any compounded product contains at least one drug or drug class that is not recommended, the compounded product is not recommended. Flurbiprofen is a non-steroidal anti-inflammatory drug (NSAID). Topical NSAIDs are indicated for osteoarthritis and tendinitis, in particular that of the knee and elbow or other joints that are amenable to topical treatment. There is little evidence to utilize topical NSAIDs for treatment of osteoarthritis of the spine, hip, or shoulder. Note that topical flurbiprofen is not FDA approved, and is therefore experimental and cannot be presumed as safe

and efficacious. Non-FDA approved medications are not medically necessary. The treating physician is prescribing oral and transdermal NSAIDs. This is duplicative, potentially toxic, and excessive, as topical NSAIDs are absorbed systemically. Lidocaine is only FDA approved for treating post-herpetic neuralgia, and the dermal patch form (Lidoderm) is the only form indicated for neuropathic pain. No other commercially approved topical formulations of lidocaine (whether creams, lotions, or gels) are indicated for neuropathic pain. Non-dermal patch forms are generally indicated as local anesthetics or anti-pruritics. There was no documentation of neuropathic pain or postherpetic neuralgia for this injured worker, and no documentation of trial and failure of first line agents. As neither of the agents in this compounded topical product are recommended, the compound is not recommended. As such, the request for Flurbiprofen Lidocaine cream is not medically necessary.

**Cane:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG-TWC Procedure Summary Online Version last updated 06/05/2014.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) knee and leg chapter: walking aids.

**Decision rationale:** The ODG recommends the use of walking aides such as canes for persons with knee osteoarthritis. Assistive devices for ambulation can reduce pain associated with osteoarthritis. Frames or wheeled walkers are preferable for patients with bilateral disease. Contra lateral cane placement is the most efficacious for persons with knee osteoarthritis. There was no documentation that this injured worker had osteoarthritis. Although unstable gait and weakness were noted, no detailed musculoskeletal or neurological examinations were documented. There was no documentation of evaluation for these findings. Due to lack of specific indication, the request for a cane is not medically necessary.

**Urine toxicology screen:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation ODG-TWC Pain Procedure Summary last updated 02/23/2015.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines drug testing p. 43, opioids Page(s): 43, 77-78, 89, 94. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) chronic pain chapter: urine drug testing.

**Decision rationale:** Per MTUS chronic pain medical treatment guidelines, urine drug screens are recommended as an option to assess for the use or the presence of illegal drugs, in accordance with a treatment plan for use of opioid medication, and as a part of a pain treatment agreement for opioids. Per the ODG, urine drug testing is recommended as a tool to monitor compliance with prescribed substances, identify use of undisclosed substances, and uncover

diversion of prescribed substances. Urine drug testing is recommended at the onset of treatment when chronic opioid management is considered, if the patient is considered to be at risk on addiction screening, or if aberrant behavior or misuse is suspected or detected. Ongoing monitoring is recommended if a patient has evidence of high risk of addiction and with certain clinical circumstances. Frequency of urine drug testing should be based on risk stratification. Patients with low risk of addiction/aberrant behavior should be tested within six months of initiation of therapy and on a yearly basis thereafter. Patients at moderate risk for addiction/aberrant behavior should be tested 2-3 times per year. Patients at high risk of adverse outcomes may require testing as often as once a month. Random collection is recommended. Results of testing should be documented and addressed. In this case, Norco has been prescribed for at least 6 months. No risk assessment for aberrant behavior was documented, which would be required for determination of frequency of testing. A urine drug screen from January 2015 was submitted and was inconsistent with prescribed medications, as hydrocodone was not detected; this finding may be indicative of possible diversion and was not addressed by the treating physician. The treating physician has not provided an adequate response to the prior failed drug test. Prescribing after the failed tests did not change and there was no change in the treatment plan in response to the failed test. Drug tests which are performed without a meaningful response from the treating physician are not indicated. In addition, the associated opioid in this case has been determined to be not medically necessary. Due to lack of risk assessment for aberrant behavior, lack of response to prior failed urine drug testing, and lack of medical necessity of the associated opiate, the request for urine toxicology screen is not medically necessary.