

Case Number:	CM15-0097786		
Date Assigned:	05/29/2015	Date of Injury:	08/19/2004
Decision Date:	06/29/2015	UR Denial Date:	04/22/2015
Priority:	Standard	Application Received:	05/21/2015

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 was a 45 year old male, who sustained an industrial injury, August 19, 2004. The injured worker previously received the following treatments TENS (transcutaneous electrical nerve stimulator) unit at home, home exercise program including treadmill, lumbar spine MRI, topical Menthol, back brace, ice therapy, EMG/NCS (electrodiagnostic studies and nerve conduction studies) of the lower extremities were negative for radiculopathy, Norco, Naproxen and Omeprazole. The injured worker was diagnosed with bilateral lumbar radiculopathy with MRI abnormality especially at L4-L5, secondary upset stomach due top medication use, occasional erectile dysfunction due to chronic low back pain. According to progress note of March 23, 2015, the injured workers chief complaint was lumbar spine pain. The injured worker rated the pain at 5 out of 10. The pain decreased to 0 out of 10 with medications. The medications allowed the injured worker to do activities of daily living, working, grocery shopping and household chores. The injured worker continued TENS (transcutaneous electrical nerve stimulator) unit, back brace and exercise and finds all of these helpful for mitigating the pain. The physical exam noted 4 out of 5 muscle strength of the lower extremities. The sensory exam noted altered sensation over the top of the left foot in the L5 dermatome; no definite decreased sensation was noted. The injured worker straight gait was slow due to low back pain. There was slight to moderate paralumbar muscle tenderness and muscle spasm, more on the right than the left. There was decreased range of motion to the lumbar spine by 30%. The straight leg raises was positive on the left. According to the progress note, the injured worker rarely took Norco. The injured worker took Omeprazole for gastrointestinal upset. The treatment plan included prescriptions for Norco, Naproxen and Omeprazole.

IMR ISSUES, DECISIONS AND RATIONALES

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

Norco 5/325mg, #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, specific drug list, Hydrocodone/Acetaminophen; When to Discontinue Opioids.

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, including Norco. These guidelines have established criteria of the use on 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 As 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 As 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.

Naproxen 550mg, #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Naproxen; NSAIDs, specific drug list & adverse effects; Nonselective NSAIDs.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): 67-68.

Decision rationale: The MTUS/Chronic Pain Medical Treatment Guidelines comment on the use of NSAIDs such as Naproxen, as a treatment modality. In general, NSAIDs are only recommended for short-term use; particularly for exacerbations of chronic pain. Specific recommendations: Osteoarthritis (including knee and hip): 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 naproxen being the safest drug). There is no evidence of long-term effectiveness for pain or function. Back Pain - Acute exacerbations of chronic pain: Recommended as a second-line treatment after acetaminophen. In general, there is conflicting evidence that NSAIDs are more effective than acetaminophen for acute LBP. For patients with acute low back pain with sciatica a recent Cochrane review (including three heterogeneous randomized controlled trials) found no differences in treatment with NSAIDs vs. placebo. In patients with axial low back pain this same review found that NSAIDs were not more effective than acetaminophen for acute low-back pain, and that acetaminophen had fewer side effects. The addition of NSAIDs or spinal manipulative therapy does not appear to increase recovery in patients with acute low back pain over that received with acetaminophen treatment and advice from their physician. Back Pain - Chronic low back pain: Recommended as an option for short-term symptomatic relief. A Cochrane review of the literature on drug relief for low back pain (LBP) suggested that NSAIDs were no more effective than other drugs such as acetaminophen, narcotic analgesics, and muscle relaxants. The review also found that NSAIDs had more adverse effects than placebo and acetaminophen but fewer effects than muscle relaxants and narcotic analgesics. In addition, evidence from the review suggested that no one NSAID, including COX-2 inhibitors, was clearly more effective than another. Neuropathic pain: There is inconsistent evidence for the use of these medications to treat long-term neuropathic pain, but they may be useful to treat breakthrough and mixed pain conditions such as osteoarthritis (and other nociceptive pain) in with neuropathic pain. In this case, the records indicate that Naproxen is being used as a long-term treatment strategy for this patient's symptoms. As noted in the above cited guidelines, long-term use is not recommended. For this reason, Naproxen is not considered as a medically necessary treatment.

Omeprazole 20mg, #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk.

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

Decision rationale: The MTUS/Chronic Pain Medical Treatment Guidelines comment on the use of proton pump inhibitors, including Omeprazole. In general, proton pump inhibitors (PPIs) are used to decrease the risk of a gastrointestinal event, such as an ulcer or a GI bleed, in a patient on an NSAID. The specific MTUS recommendations are as follows: 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 (200 µg 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, the records provide no evidence that this patient is at significant risk for a gastrointestinal event. The information from the records indicate that the patient has none of these above stated risk factors. For this reason, the use of a PPI such as Omeprazole is not medically necessary.