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| <b>Case Number:</b>   | CM13-0014935 |                              |            |
| <b>Date Assigned:</b> | 03/12/2014   | <b>Date of Injury:</b>       | 03/15/2004 |
| <b>Decision Date:</b> | 04/23/2014   | <b>UR Denial Date:</b>       | 08/07/2013 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 08/22/2013 |

### 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. The expert reviewer is Board Certified in Emergency Medicine and is licensed to practice in New York. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### 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 patient is a 51-year-old female who was injured on March 15, 2004. The patient continued to experience pain in her shoulders, lumbosacral spine, and neck. Physical examination was notable for MRI of the lumbar spine, done on September 12, 2013, showed multilevel disc bulges with no evidence of canal stenosis. Diagnoses included lumbar sprain/strain, lumbar radiculopathy, cervical sprain/strain, myofascial syndrome and chronic pain syndrome. Treatment included medications, epidural steroid injections, trigger point injections, physical therapy, and chiropractic therapy. Requests for authorization for subutex 8 mg # 60, norco 10/3325, # 120, urine drug screen, Medrox patch, #30, Ambien 10 mg # 30, Zanaflex 4 mg # 90, and one re-evaluation were submitted for consideration.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**SUBUTEX 8MG, #60:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines BUPRENORPHINE Page(s): 26-27.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines PAIN INTERVENTIONS Page(s): 26-27.

**Decision rationale:** Subutex is the opioid buprenorphine. Buprenorphine is a partial agonist at the mu-receptor (the classic morphine receptor) and an antagonist at the kappa-receptor (the receptor that is thought to produce alterations in the perception of pain, including emotional response). It is recommended as an option for treatment of chronic pain (consensus based) in selected patients (not first-line for all patients). Suggested populations are as follows: (1) Patients with a hyperalgesic component to pain; (2) Patients with centrally mediated pain; (3) Patients with neuropathic pain; (4) Patients at high-risk of non-adherence with standard opioid maintenance; (5) For analgesia in patients who have previously been detoxified from other high-dose opioids. Due to complexity of induction and treatment the drug should be reserved for use by clinicians with experience. IN this case the patient had been treated with opioids since at least November 2012. The patient was not obtaining relief from the opioids. In addition there is no documentation that the patient had signed an opioid contract. When analgesia is not obtained the patient should be weaned from the opioid medications. Criteria for long-term use of opioids have not been met. The request is not authorized.

**NORCO 10/325MG, #120:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines OPIOIDS: CRITERIA FOR USE Page(s): 78-82.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines PAIN INTERVENTIONS Page(s): 74-96.

**Decision rationale:** Norco is the compounded medication containing hydrocodone and acetaminophen. Chronic Pain Medical Treatment Guidelines state that opioids are not recommended as a first line therapy. Opioid should be part of a treatment plan specific for the patient and should follow criteria for use. Criteria for use include establishment of a treatment plan, determination if pain is nociceptive or neuropathic, failure of pain relief with non-opioid analgesics, setting of specific functional goals, and opioid contract with agreement for random drug testing. If analgesia is not obtained, opioids should be discontinued. The patient should be screened for likelihood that he or she could be weaned from the opioids if there is no improvement in pain of function. It is recommended for short term use if first-line options, such as acetaminophen or NSAIDS have failed. IN this case the patient had been treated with opioids since at least November 2012. The patient was not obtaining relief from the opioids. In addition there is no documentation that the patient had signed an opioid contract. When analgesia is not obtained the patient should be weaned from the opioid medications. Criteria for long-term use of opioids have not been met. The medication is not be authorized.

**RETROSPECTIVE URINE DRUG SCREEN (7/16/13):** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines DRUG TESTING Page(s): 43. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG), OPIOIDS.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines PAIN INTERVENTIONS Page(s): 78.

**Decision rationale:** Chronic Pain Medical Treatment Guidelines state that urinary drug testing should be used if there are issues of abuse, addiction, or pain control in patients being treated with opioids. ODG criteria for Urinary Drug testing are recommended for patients with chronic opioid use. Patients at low risk for addiction/aberrant behavior should be tested within 6 months of initiation of therapy and yearly thereafter. Those patients with moderate risk for addiction/aberrant behavior should undergo testing 2-3 times/year. Patients with high risk of addiction/aberrant behavior should be tested as often as once per month. In this case the patient had not been exhibiting aberrant behavior. In addition she had drug testing done in January 2013, November 2012, October 2012, September 2012. In cases where there is low risk for aberrant or addictive behavior testing should be done annually. This patient had frequent drug testing. Medical necessity is not established for increased frequency of urine drug testing.

**MEDROX PATCH QTY: 30:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines TOPICAL ANALGESICS Page(s): 111-113.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines PAIN INTERVENTIONS Page(s): 111-112.

**Decision rationale:** Medrox patch is a topical analgesic containing methylsalicylate, menthol, and capsaicin. Topical analgesics are recommended for neuropathic pain when anticonvulsants and antidepressants have failed. There is not documentation that this patient has been treated with either of those class of medications. Compounded topical analgesics are commonly prescribed and there is little to no research to support the use of these compounds. Furthermore, the guidelines state that "Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended." Methylsalicylate is a topical salicylate and is recommended, being significantly better than placebo in chronic pain. There are no guidelines present for menthol. The lack of information does not allow determination for medical necessity and safety. It cannot be recommended. Capsaicin is recommended only as an option in patients who have not responded or cannot tolerate other treatments. It is recommended for osteoarthritis, fibromyalgia, and chronic non-specific back pain and is considered experimental in high doses. It is not recommended in this case. This compounded drug is not recommended. It contains two drugs that are not recommended. Therefore it is not certified.

**AMBIEN 10MG, #30:** 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 CHAPTER, ZOLPIDEM(AMBIEN).

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG), PAIN ZOLPIDEM.

**Decision rationale:** Ambien is the anti-insomnia medication called Zolpidem. Zolpidem is a prescription short-acting nonbenzodiazepine hypnotic, which is approved for the short-term (usually two to six weeks) treatment of insomnia. Proper sleep hygiene is critical to the individual with chronic pain and often is hard to obtain. Various medications may provide short-term benefit. While sleeping pills, so-called minor tranquilizers, and anti-anxiety agents are commonly prescribed in chronic pain, pain specialists rarely, if ever, recommend them for long-term use. They can be habit-forming, and they may impair function and memory more than opioid pain relievers. There is also concern that they may increase pain and depression over the long-term. Cognitive behavioral therapy (CBT) should be an important part of an insomnia treatment plan. A study of patients with persistent insomnia found that the addition of zolpidem immediate release to CBT was modestly beneficial during acute (first 6 weeks) therapy, but better long-term outcomes were achieved when zolpidem IR was discontinued and maintenance CBT continued. In this case the patient had been treated with Ambien since at least November 2012. The duration of therapy surpasses the recommended 6 weeks maximum. In addition the patient was not participating in cognitive behavior treatment as is recommended for the insomnia treatment. The medication is not be authorized.

**ZANAFLEX 4MG, #90:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines ANTISPASTICITY/ANTISPASMODIC DRUGS Page(s): 66.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines PAIN INTERVENTIONS Page(s): 63, 65..

**Decision rationale:** Zanaflex is the muscle relaxant Tizanidine. Tizanidine is a muscle relaxant that acts centrally as an alpha2-adrenergic agonist that is FDA approved for management of spasticity. Side effects include somnolence, dizziness, dry mouth, hypotension, weakness, and hepatotoxicity. Non-sedating muscle relaxants are recommended with caution as a second-line option for short-term treatment (less than two weeks) 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. In this case the patient had not been treated with the medication sine at least November 2012. This surpasses the recommended maximum duration of 2 weeks. In addition this medication is FDA approved as an antispasmodic. There is no documented muscle spasm on physical examination. Medical necessity has not been established.

**ONE RE-EVALUATION:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Page(s): 127.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG), SHOULDER: OFFICE VISITS; NECK AND UPPER BACK: OFFICE VISITS, LOW BACK : THORACIC & LUMBAR.

**Decision rationale:** MTUS does not comment on office visit. ODG recommends office visits as determined to be medically necessary. Evaluation and management outpatient visits to the offices of medical doctor play a critical role in the proper diagnosis and return to function of an injured worker, and they should be encouraged. The need for a clinical office visit with a health care provider is individualized based upon a review of the patient concerns, signs and symptoms, clinical stability, and reasonable physician judgment. The determination is also based on what medications the patient is taking, since some medicines such as opiates, or medicines such as certain antibiotics, require close monitoring. As patient conditions are extremely varied, a set number of office visits per condition cannot be reasonably established. The determination of necessity for an office visit requires individualized case review and assessment, being ever mindful that the best patient outcomes are achieved with eventual patient independence from the health care system through self care as soon as clinically feasible. The number of automatically covered visits for shoulder, low back, or neck complaints is 6. The patient had at least 11 visits from October 25, 2012, occurring every 3 weeks from January 28, 2013. Injury had occurred almost 10 years prior to the evaluations. Frequent re-evaluations are reasonable and necessary in the acute phase of the injury. This patient was no longer in the acute phase of the injury. There are no anticipated major changes in the patient's treatment. In addition the the evaluations from July 2013 on do not include any physical examination other than the vital signs. There is no documentation that the patient independence from the health care system was being established. Medical necessity has not been established.