

Case Number:	CM13-0057132		
Date Assigned:	12/30/2013	Date of Injury:	08/10/1979
Decision Date:	04/07/2014	UR Denial Date:	10/30/2013
Priority:	Standard	Application Received:	11/25/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Pain Management, has a subspecialty in Disability Evaluation and is licensed to practice in California. 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 physician 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 63 year old male with a date of injury of 8/10/1979. Under consideration are prospective requests for a urine drug screen, a prescription of Vicodin 5/500mg #90, and a prescription of Flexeril 10 mg #90. The patient had been diagnosed with lumbar radiculopathy, chronic pain syndrome, bilateral knee pain left greater than right, bilateral knee internal derangement left greater than right, myofascial syndrome, neuropathic pain, chronic pain-related depression, and prescription narcotic dependence. Per the 10/21/2013 report by [REDACTED], the patient had bilateral knee pain and low back pain. There was developing pain and swelling in the left knee which sometimes required the use of a walker. The left knee pain was causing the low back to flare up due to favoring left knee. Pain relief with vicodin was reported to be 50% and allowed for standing longer, walking further and washing dishes without pain. When taking vicodin, the patient felt motivated to get out and do things. Current pain was rated 8/10, average pain 9/10 over the preceding week. Without medications pain was rated 8/10 and 4/10 with medications. Objective findings included vital signs. At this time the provider is recommending a urine drug screen, vicodin, and Flexeril.

IMR ISSUES, DECISIONS AND RATIONALES

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

Urine drug screen: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM, Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation (ODG) Official Disability Guidelines

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Urine drug screen Page(s): 43.

Decision rationale: The California Chronic Pain Medical Treatment Guidelines recommends frequent random urine toxicology screens to help avoid misuse of opiates or other controlled substances. Frequent random drug screen should be used in cases where patients have physical exam findings or history for misuse of controlled substances. Another urine drug screen is not indicated at this time. Previously a request for a urine drug screen was approved in review [REDACTED] on 10/3/2013. The available documents did not reveal that the previously approved urine drug screen was completed. Therefore the request for repeat urine drug screening test is not medically necessary.

Vicodin 5/500mg, #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Weaning of Medications, Non-Steroidal Anti-Inflammatory Drugs (NSA).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 75-76.

Decision rationale: California Chronic Pain Medical Treatment Guidelines recommend opioids as a short-term second-line drug for moderate to severe chronic pain. Long-term use of opioids is generally not recommended, but may be necessary if certain criteria are met. These include significant reduction in pain compared to baseline, but not complete abatement; functional improvement as compared to baseline; no reported significant adverse side effects; and no reported abuse or misuse of the opioids. Outcome measures should not be solely focused on pain intensity and should incorporate other forms such as functional level, appropriate medication use and side effects. If there are signs of misuse, these concerns should be addressed immediately with the patient. Most chronic pain will not resolve while there is active and ongoing alcohol, illicit drug, or prescription drug abuse. Regarding vicodin, dose recommendation for the usual dose of 5/500mg is one or two tablets every four to six hours as needed for pain with a maximum daily limit of eight tablets. For doses oxycodone over 5mg, one tablet every four to six hours as need for pain with a recommended maximum dose of 60mg daily. Maximum daily dosage of acetaminophen should not exceed 4g daily. Abrupt discontinuation is not recommended due to the potential for withdrawal. Tapering at the rate of 20 to 50% of the original dose is recommended for patients who are not addicted. Slower tapering is otherwise suggested at a rate of 10% every two to four weeks and slowed to 5% once a dose 1/3 of the original does have been reached. The previous request for Vicodin 5/500 was modified to #81 for tapering in review [REDACTED] on 10/3/2013 based on the lack of pain reduction or functional improvement with use. Although the patient was reported to have 50% pain improvement and was able to stand longer, walk further and wash dishes without pain while taking Vicodin, there was a history of concurrent alcohol and marijuana use as detected on urine screens. Ethyl alcohol was detected on urine drug screens performed on 4/11/2013 and 5/2/2013. Although subsequent testing did not detect alcohol, the 9/6/2013 drug screen was positive for tetrahydrocannabinol (THC) indicative of marijuana use. It was not readily evident from the records, whether the patient had a

prescription for medicinal marijuana as its presence on the drug screen was not discussed in the report. Given the inconsistent results of the prior drug screens and the provider's silence regarding these results, the request for Vicodin 5/500 #90 is not medically appropriate.

Flexeril 10mg, #90: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antispasmodics Page(s): 64.

Decision rationale: According to the California Chronic Pain Medical Treatment Guidelines, non-sedating muscle relaxants are recommended with caution as a second-line option for short-term treatment of acute exacerbation of chronic low back pain. However, in most low back pain cases, there are no additional benefits regarding pain relief compared to NSAIDs. Cyclobenzaprine (Flexeril) is indicated for a short course of 2-3 weeks for the treatment of muscle spasms and management of back pain. The benefit is modest and has a potential for greater adverse effects. Dosing start at 5mg three times a day and can be increased to 10mg three times a day. Flexeril is not indicated. Flexeril was being used since at least 5/23/2013 as the urine drug screen detected cyclobenzaprine. Use beyond 2-3 weeks is not recommended by the guidelines and during the most recent visit on 10/21/2013, there was no documentation of subjective or objective signs of muscle spasms or whether the patient had favorable response to Flexeril.