

<b>Case Number:</b>	CM14-0145704		
<b>Date Assigned:</b>	09/15/2014	<b>Date of Injury:</b>	09/28/2001
<b>Decision Date:</b>	12/03/2014	<b>UR Denial Date:</b>	08/27/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/08/2014

### 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 Family Medicine 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 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:

This is a 47-year-old male patient who reported an industrial injury on 9/28/2001, over 13 years ago, attributed to the performance of his usual and customary job duties. The patient is being treated by pain management for chronic low back pain. The patient reported continued pain however, no changes to the nature of the pain. The patient is being prescribed Soma 350 mg TID; Lidoderm 5% patches; Norco 10/325 mg #90 as dispensed maximum six (6) per day; Duragesic 25 mcg/hr; and Dextroamphetamine ER 5 mg capsule. The patient has been treated with a spinal cord stimulator with electrodes at the T8-T9 level. The objective findings on examination included height 6'1"; weight 225 pounds; antalgic gait; ambulates with cane; surgical scars to the lumbar spine; range of motion is diminished; tenderness is noted to the paravertebral muscles; unable to walk on heels; able to walk on toes; lumbar facet loading is positive on the left side; SLR is negative; tenderness over the SI spine; motor strength of EHL is 5/5 along with muscle strength 5/5; light touch sensation is decreased over lateral calf and posterior calf on the left side. The diagnoses included s/p lumbar laminectomy syndrome; lumbar radiculopathy; and low back pain. The treatment plan included the continued prescription of opioids including Norco 10/1025 mg; Soma 350 mg; Lidoderm patches; Colace; and Senokot.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Norco 10/325mg #90, take 1 every 4-6 hours as needed for pain (max 6/day): 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): 74-97. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) ODG pain chapter-opioids

**Decision rationale:** Evidence-based guidelines recommend short-term use of opioids for the management of chronic nonmalignant moderate to severe pain. Long-term use is not recommended for nonmalignant pain due to addiction, dependency, intolerance, abuse, misuse, and/or side effects. Ongoing opioid management criteria are required for long-term use with evidence of reduce pain and improve function as compared to baseline measurements or a return to work. The prescription for Hydrocodone-APAP (Norco) 10/325 mg #90 for short acting pain is being prescribed as an opioid analgesic for the treatment of chronic pain to the back for the date of injury 13 years ago. The objective findings on examination do not support the medical necessity for continued opioid analgesics. The patient is being prescribed opioids for chronic mechanical low back pain, which is inconsistent with the recommendations of the CA MTUS. There is no objective evidence provided to support the continued prescription of opioid analgesics for the cited diagnoses and effects of the industrial claim. The patient should be titrated down and off the prescribed Hydrocodone. The patient is 13 years s/p DOI with reported continued issues postoperatively; however, there is no rationale supported with objective evidence to continue the use of opioids. There is no demonstrated medical necessity for the continuation of opioids for the effects of the industrial injury. The chronic use of Hydrocodone-APAP/Norco is not recommended by the CA MTUS; the ACOEM Guidelines, or the Official Disability Guidelines for the long-term treatment of chronic back/knee pain. There is no demonstrated sustained functional improvement from the prescribed high dose opioids. The prescription of opiates on a continued long-term basis is inconsistent with the CA MTUS and the Official Disability Guidelines recommendations for the use of opiate medications for the treatment of chronic pain. There is objective evidence that supports the use of opioid analgesics in the treatment of this patient over the use of NSAIDs for the treatment of chronic pain. The current prescription of opioid analgesics is inconsistent with evidence-based guidelines. The prescription of opiates on a continued long-term basis is inconsistent with the Official Disability Guidelines recommendations for the use of opiate medications for the treatment of chronic pain. There is objective evidence that supports the use of opioid analgesics in the treatment of this patient over the use of NSAIDs for the treatment of chronic pain issues. Evidence-based guidelines necessitate documentation that the patient has signed an appropriate pain contract, functional expectations have been agreed to by the clinician, and the patient, pain medications will be provided by one physician only, and the patient agrees to use only those medications recommended or agreed to by the clinician to support the medical necessity of treatment with opioids. The ACOEM Guidelines updated chapter on chronic pain state, "Opiates for the treatment of mechanical and compressive etiologies: rarely beneficial. Chronic pain can have a mixed physiologic etiology of both neuropathic and nociceptive components. In most cases, analgesic treatment should begin with acetaminophen, aspirin, and NSAIDs (as suggested by the WHO step-wise algorithm). When these drugs do not satisfactorily reduce pain, opioids for moderate to moderately severe pain may be added to (not substituted for) the less efficacious drugs. A major concern about the use of opioids for chronic pain is that most randomized

controlled trials have been limited to a short-term period (70 days). This leads to a concern about confounding issues; such as, tolerance, opioid-induced hyperalgesia, long-range adverse effects, such as, hypogonadism and/or opioid abuse, and the influence of placebo as a variable for treatment effect." ACOEM guidelines state that opioids appear to be no more effective than safer analgesics for managing most musculoskeletal symptoms; they should be used only if needed for severe pain and only for a short time. The long-term use of opioid medications may be considered in the treatment of chronic musculoskeletal pain, If: The patient has signed an appropriate pain contract; Functional expectations have been agreed to by the clinician and the patient; Pain medications will be provided by one physician only; The patient agrees to use only those medications recommended or agreed to by the clinician. ACOEM also note, "Pain medications are typically not useful in the subacute and chronic phases and have been shown to be the most important factor impeding recovery of function." There is no clinical documentation by with objective findings on examination to support the medical necessity of Hydrocodone-APAP for this long period of time or to support ongoing functional improvement. There is no provided evidence that the patient has received benefit or demonstrated functional improvement with the prescribed Hydrocodone-APAP. There is no demonstrated medical necessity for the prescribed Opioids. There is no demonstrated medical necessity for the current prescription of tramadol with Norco. The continued prescription for Norco 10/325 mg #90 with is not demonstrated to be medically necessary. Therefore this request is not medically necessary.

**Norco 10/325mg #180, take 1 every 4-6 hours as needed for pain (max 6/day): 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): 74-97. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) Official Disability Guidelines (ODG) pain chapter-opioids

**Decision rationale:** Evidence-based guidelines recommend short-term use of opioids for the management of chronic nonmalignant moderate to severe pain. Long-term use is not recommended for nonmalignant pain due to addiction, dependency, intolerance, abuse, misuse, and/or side effects. Ongoing opioid management criteria are required for long-term use with evidence of reduce pain and improve function as compared to baseline measurements or a return to work. The prescription for Hydrocodone-APAP (Norco) 10/325 mg #180 for short acting pain is being prescribed as an opioid analgesic for the treatment of chronic pain to the back for the date of injury 13 years ago. The objective findings on examination do not support the medical necessity for continued opioid analgesics. The patient is being prescribed opioids for chronic mechanical low back pain, which is inconsistent with the recommendations of the CA MTUS. There is no objective evidence provided to support the continued prescription of opioid analgesics for the cited diagnoses and effects of the industrial claim. The patient should be titrated down and off the prescribed Hydrocodone. The patient is 13 years s/p DOI with reported continued issues postoperatively; however, there is no rationale supported with objective evidence to continue the use of opioids. There is no demonstrated medical necessity for the continuation of opioids for the effects of the industrial injury. The chronic use of Hydrocodone-

APAP/Norco is not recommended by the CA MTUS; the ACOEM Guidelines, or the Official Disability Guidelines for the long-term treatment of chronic back/knee pain. There is no demonstrated sustained functional improvement from the prescribed high dose opioids. The prescription of opiates on a continued long-term basis is inconsistent with the CA MTUS and the Official Disability Guidelines recommendations for the use of opiate medications for the treatment of chronic pain. There is objective evidence that supports the use of opioid analgesics in the treatment of this patient over the use of NSAIDs for the treatment of chronic pain. The current prescription of opioid analgesics is inconsistent with evidence-based guidelines. The prescription of opiates on a continued long-term basis is inconsistent with the Official Disability Guidelines recommendations for the use of opiate medications for the treatment of chronic pain. There is objective evidence that supports the use of opioid analgesics in the treatment of this patient over the use of NSAIDs for the treatment of chronic pain issues. Evidence-based guidelines necessitate documentation that the patient has signed an appropriate pain contract, functional expectations have been agreed to by the clinician, and the patient, pain medications will be provided by one physician only, and the patient agrees to use only those medications recommended or agreed to by the clinician to support the medical necessity of treatment with opioids. The ACOEM Guidelines updated chapter on chronic pain states, "Opiates for the treatment of mechanical and compressive etiologies: rarely beneficial. Chronic pain can have a mixed physiologic etiology of both neuropathic and nociceptive components. In most cases, analgesic treatment should begin with acetaminophen, aspirin, and NSAIDs (as suggested by the WHO step-wise algorithm). When these drugs do not satisfactorily reduce pain, opioids for moderate to moderately severe pain may be added to (not substituted for) the less efficacious drugs. A major concern about the use of opioids for chronic pain is that most randomized controlled trials have been limited to a short-term period (70 days). This leads to a concern about confounding issues; such as, tolerance, opioid-induced hyperalgesia, long-range adverse effects, such as, hypogonadism and/or opioid abuse, and the influence of placebo as a variable for treatment effect." ACOEM guidelines state that opioids appear to be no more effective than safer analgesics for managing most musculoskeletal symptoms; they should be used only if needed for severe pain and only for a short time. The long-term use of opioid medications may be considered in the treatment of chronic musculoskeletal pain, If: The patient has signed an appropriate pain contract; Functional expectations have been agreed to by the clinician and the patient; Pain medications will be provided by one physician only; The patient agrees to use only those medications recommended or agreed to by the clinician. ACOEM also note, "Pain medications are typically not useful in the subacute and chronic phases and have been shown to be the most important factor impeding recovery of function." There is no clinical documentation by with objective findings on examination to support the medical necessity of Hydrocodone-APAP for this long period of time or to support ongoing functional improvement. There is no provided evidence that the patient has received benefit or demonstrated functional improvement with the prescribed Hydrocodone-APAP. There is no demonstrated medical necessity for the prescribed Opioids. There is no demonstrated medical necessity for the current prescription of tramadol with Norco. The continued prescription for Norco 10/325 mg #180 with is not demonstrated to be medically necessary. Therefore this request is not medically necessary.

**Soma 350mg tablet #90, take 1 three times daily as needed: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment, Chapter 8 Neck and Upper Back Complaints Page(s): 47. 128. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter--muscle relaxants and Carisoprodol

**Decision rationale:** The patient is prescribed Carisoprodol/SOMA 350 mg #90 on a routine basis for the treatment of chronic pain and is not directed to muscle spasms on a prn basis. The CA MTUS does not recommend the prescription of Carisoprodol. There is no medical necessity for the prescribed Soma 350 mg #90 for chronic pain or muscle spasms as it is not recommended by evidence based guidelines. The prescription of Carisoprodol is not recommended by the CA MTUS for the treatment of injured workers. The prescription of CARISOPRODOL as a muscle relaxant is not demonstrated to be medically necessary for the treatment of the chronic back pain on a routine basis. The patient has been prescribed CARISOPRODOL on a routine basis for muscle spasms. There is no demonstrated medical necessity for the daily prescription of CARISOPRODOL as a muscle relaxer on a daily basis for chronic pain. The prescription of CARISOPRODOL for use of a muscle relaxant for cited chronic pain is inconsistent with the recommendations of the CA MTUS, the ACOEM Guidelines, and the Official Disability Guidelines. The use of alternative muscle relaxants was recommended by the CA MTUS and the Official Disability Guidelines for the short-term treatment of chronic pain with muscle spasms; however, muscle relaxants when used are for short-term use for acute pain and are not demonstrated to be effective in the treatment of chronic pain. The use of Carisoprodol is associated with abuse and significant side effects related to the psychotropic properties of the medication. The centrally acting effects are not limited to muscle relaxation. The prescription of CARISOPRODOL as a muscle relaxant is not recommended as others muscle relaxants that without psychotropic effects are readily available. There is no medical necessity for CARISOPRODOL 350 mg #90. The California MTUS guidelines state that CARISOPRODOL is not recommended. This medication is not indicated for long-term use. Carisoprodol is a commonly prescribed centrally acting skeletal muscle relaxant whose primary active metabolite is meprobamate a schedule for controlled substance. It has been suggested that the main effect is due to generalize sedation and treatment of anxiety. Abuses been noted for sedative and relaxant effects. In regular abusers, the main concern is for the accumulation of meprobamate. Carisoprodol abuses also been noted in order to augment or alter effects of other drugs. This includes the following increasing sedation of benzodiazepines or alcohol; used to prevent side effects of cocaine; use with tramadol to ghost relaxation and euphoria; as a combination with hydrocodone as an effective some abuses claim is similar to heroin referred to as a Las Vegas cocktail; and as a combination with codeine referred to as Carisoprodol Coma. There is no documented functional improvement with the use of the prescribed Carisoprodol. The use of CARISOPRODOL/SOMA is not recommended due to the well-known psychotropic properties. Therefore, this medication should be discontinued. There is no demonstrated medical necessity for soma 350 mg #90. Therefore this request is not medically necessary.