

<b>Case Number:</b>	CM14-0156277		
<b>Date Assigned:</b>	10/28/2014	<b>Date of Injury:</b>	11/21/2000
<b>Decision Date:</b>	12/04/2014	<b>UR Denial Date:</b>	09/22/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/24/2014

### 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 Internal 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 55 year old female with a date of injury of 11/21/2000. On 04/18/2014 she was taking ultracet, Trazodone, Neurontin, Valium, Prozac, Ambilify and Zanaflex and was walking on a regular basis. On 05/22/2014 it was noted that she was treated for anxiety and depression with valium, Prozac and Ambilify. On 06/13/2014 she had an office visit with a MD. He had a history of aberrant urine drug screen but was taking Norco, Trazodone, Flexeril, Neurontin and from a psychiatrist was taking Valium, Prozac and Abilify. Ultracet was prescribed and there was no documentation that Norco was discontinued. On 08/13/2014 she had cervical paraspinal muscle, right shoulder and back pain. She had left arm and left hand parasthesias. Previously her drug screen was positive for cocaine and Norco was switched to Ultraset. She was prescribed Valium, Prozac and Abilify by a psychiatrist. Her other treating provider, a chiropractor, prescribed Ultracet, Flexeril, Trazodone HS and Neurontin. She had exophthalmos and her family physician checked her thyroid function and it was normal. The listed diagnoses included neck pain, left shoulder pain, low back pain, social isolation and depression and aberrant urine drug screen.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Ultracet 37.5/325mg #240:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids On-going Management Page(s): 78-80.

**Decision rationale:** The Expert Reviewer's decision rationale:Chronic Pain Medical Treatment Guidelines MTUS (Effective July 18, 2009) Page 78. 4) On-Going Management. Actions Should Include:(a) Prescriptions from a single practitioner taken as directed, and all prescriptions from a single pharmacy. (b) The lowest possible dose should be prescribed to improve pain and function. (c) Office: 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. Information from family members or other caregivers should be considered in determining the patient's response to treatment. The 4 A's for Ongoing Monitoring: Four domains have been proposed as most relevant for ongoing monitoring of chronic pain patients on opioids: pain relief, side effects, physical and psychosocial functioning, and the occurrence of any potentially aberrant (or nonadherent) drug-related behaviors. These domains have been summarized as the "4 A's" (analgesia, activities of daily living, adverse side effects, and aberrant drug taking behaviors). The monitoring of these outcomes over time should affect therapeutic decisions and provide a framework for documentation of the clinical use of these controlled drugs. (Passik, 2000) (d) Home: To aid in pain and functioning assessment, the patient should be requested to keep a pain diary that includes entries such as pain triggers, and incidence of end-of-dose pain. It should be emphasized that using this diary will help in tailoring the opioid dose. This should not be a requirement for pain management. (e) Use of drug screening or inpatient treatment with issues of abuse, addiction, or poor pain control. (f) Documentation of misuse of medications (doctor-shopping, uncontrolled drug escalation, drug diversion). (g) Continuing review of overall situation with regard to nonopioid means of pain control. (h) 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 does not improve on opioids in 3 months. Consider a psych consult if there is evidence of depression, anxiety or irritability. Consider an addiction medicine consult if there is evidence of substance misuse. Ultracet is an opioid. She does not meet the above MTUS criteria for on-going treatment with opioids and has aberrant drug taking behavior. She has a urine drug screen positive for cocaine.

**Trazadone 50mg #120:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Anti-depressants Page(s): 13-16.

**Decision rationale:** Chronic Pain Medical Treatment Guidelines MTUS (Effective July 18, 2009) Page 13. Antidepressants for chronic pain Recommended as a first line option for neuropathic pain, and as a possibility for non-neuropathic pain. (Feuerstein, 1997) (Perrot, 2006)

Tricyclics are generally considered a first-line agent unless they are ineffective, poorly tolerated, or contraindicated. Analgesia generally occurs within a few days to a week, whereas antidepressant effect takes longer to occur. (Saarto-Cochrane, 2005) Assessment of treatment efficacy should include not only pain outcomes, but also an evaluation of function, changes in use of other analgesic medication, sleep quality and duration, and psychological assessment. Side effects, including excessive sedation (especially that which would affect work performance) should be assessed. (Additional side effects are listed below for each specific drug.) It is recommended that these outcome measurements should be initiated at one week of treatment with a recommended trial of at least 4 weeks. The optimal duration of treatment is not known because most double-blind trials have been of short duration (6-12 weeks). It has been suggested that if pain is in remission for 3-6 months, a gradual tapering of antidepressants may be undertaken. (Perrot, 2006) (Schnitzer, 2004) (Lin-JAMA, 2003) (Salerno, 2002) (Moulin, 2001) (Fishbain, 2000) (Taylor, 2004) (Gijssman, 2004) (Jick-JAMA, 2004) (Barbui, 2004) (Asnis, 2004) (Stein, 2003) (Pollack, 2003) (Ticknor, 2004) (Staiger, 2003) Long-term effectiveness of antidepressants has not been established. (Wong, 2007) The effect of this class of medication in combination with other classes of drugs has not been well researched. (Finnerup, 2005). Selective serotonin reuptake inhibitors (SSRIs), a class of antidepressants that inhibit serotonin reuptake without action on noradrenaline, are controversial based on controlled trials. Trazodone is a serotonin reuptake inhibitor and for this patient it is unclear why she is prescribed this medication when all of her psychiatric drugs are prescribed by a psychiatrist and include another serotonin uptake inhibitor - Prozac. She is also on Abilify and Valium. Additionally she had a urine screen positive for cocaine.

**Zanaflex 4mg #120:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants Page(s): 63-66.

**Decision rationale:** Chronic Pain Medical Treatment Guidelines MTUS (Effective July 18, 2009) Page 63. Muscle relaxants (for pain) Recommend non-sedating muscle relaxants with caution as a second-line option for short-term treatment of acute exacerbations in patients with chronic LBP. (Chou, 2007) (Mens, 2005) (Van Tulder, 1998) (van Tulder, 2003) (van Tulder, 2006) (Schnitzer, 2004) (See, 2008) 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. Also there is no additional benefit shown in combination with NSAIDs. Efficacy appears to diminish over time, and prolonged use of some medications in this class may lead to dependence. (Homik, 2004) Sedation is the most commonly reported adverse effect of muscle relaxant medications. These drugs should be used with caution in patients driving motor vehicles or operating heavy machinery. Drugs with the most limited published evidence in terms of clinical effectiveness include chlorzoxazone, methocarbamol, dantrolene and baclofen. (Chou, 2004) According to a recent review in American Family Physician, skeletal muscle relaxants are the most widely prescribed drug class for musculoskeletal conditions (18.5% of prescriptions), and the most commonly prescribed

antispasmodic agents are carisoprodol, cyclobenzaprine, metaxalone, and methocarbamol, but despite their popularity, skeletal muscle relaxants should not be the primary drug class of choice for musculoskeletal conditions. (See2, 2008) Classifications: Muscle relaxants are a broad range of medications that are generally divided into antispasmodics, antispasticity drugs, and drugs with both actions. (See, 2008) (van Tulder, 2006). She is taking Zanaflex long term and this is not consistent with MTUS guidelines.