

Case Number:	CM14-0174100		
Date Assigned:	10/27/2014	Date of Injury:	05/10/2002
Decision Date:	12/22/2014	UR Denial Date:	10/20/2014
Priority:	Standard	Application Received:	10/22/2014

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 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:

This worker apparently sustained his injury 05/10/2002. The nature of the injury is not known. He was apparently declared permanent and stationary date uncertain. During the course of care this worker has undergone a C4-5, C5-6 fusion in October 2002 with X-ray evidence for a solid fusion, L4-5, L5-S1 Lumbar fusion in August 2005 with a reported pseudoarthrosis at L4-5, RF ablation at those lumbar levels in May 2009 and a R RF ablation at C2, C3, C4, C5 in December 2009. The member's additional diagnoses include chronic pain, obesity, depression and anxiety related to chronic pain and a low testosterone level felt to be related to chronic narcotic ingestion. The members concerns relate to persistent pain affecting the neck, BUE, low back and BLE. Without medications pain is reported to be 10/10 and with medications 3-4/10. With medication he reports the ability to do light chores around the house and walk for exercise and without them is essentially confined to bed. Examination describes diminished ROM of the lumbar and cervical spine, normal neurological examination to include deep tendon reflexes. Normal strength in the BUE and BLE. Straight leg raising variably produced bilateral positive results with pain going into the legs. Gait is normal and he can do some walking on heels and toes. He appears to be seen monthly primarily for narcotic scripts. He has not been noted to be diverting or overusing medications and there have been reports of random urine drug tests but no results were available in these documents. He is reported to be receiving all pain management from this provider and apparently had stopped prescribed psychotropic medications from another provider without incident (meds not listed). He has been evaluated by this provider and an RFA placed for a trial of a spinal cord stimulator. His maintenance medications had been Duragesic 100 mcg q 3 days 10, Norco 10/325 qid 120, Lyrica 150 mg bid, Meloxicam 7.5 mg qd and a recent script for Flexeril 1-2 prn 30, for muscle spasms for short term and not continuous use. This addition was precipitated at the 09/25/14 visit with an annotation of cervical spine muscle

spasms on examination affecting the R trapezius, rhomboids and shoulder. SLR was noted as negative. Note is made at an October visit of an intention to leave town in November and December and a need to coordinate medications at the time that included the addition of Percocet 10/325, 90 in the absence of Duragesic in December and a dated script for Norco 10/325, 120. The member was to stay in phone contact with staff weekly until returning for his next visit. No surgical notes, X-ray, CT or MRI reports were available for review. The nature of this IMR request is to review Non-Certification for the Norco and Flexeril scripts. In both instances because of the nature of the medications weaning was recommended.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retrospective request for Norco 10/325 mg #120 (DOS 9/25/14): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, for chronic pain Page(s): 80.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 11, 79-81, 86, 87, 93, 95.

Decision rationale: A therapeutic trial of opioids should not be employed until the patient has failed a trial of non-opioid analgesics. Opioids, for long-term use, cannot be supported as there is a lack of evidence to allow for a treatment recommendation. A meta-analysis found that opioids were more effective than placebo for reducing pain intensity but the benefit for physical function was small and was considered questionable for clinical relevance. Opioids can be recommended on a trial basis for short-term use after there has been evidence of failure of first-line medication options such as acetaminophen or NSAIDs when there is evidence of moderate to severe pain. If chronic use is entertained then before initiating therapy, the patient should set goals, and the continued use of opioids should be contingent on meeting these goals. Baseline pain and functional assessments should be made. Function should include social, physical, psychological, daily and work activities. Continuation of the use of opioids would be best assessed on the basis of a return to work with evidence for improved functioning and reduced pain. The primary risk with continued use is that 36 to 56% of users have a lifetime risk for substance use disorders. Additionally there is the risk of diversion, tolerance and hyperalgesia resulting in gradual increases in medication dosing and evidence for decreasing benefits. The recommended maximal daily dosing for a morphine equivalent dose (MED) is not to exceed 120 mg per day, and for patients taking more than one opioid, the morphine equivalent dose of the different opioids must be added together to determine the cumulative dose. In this case the member is already receiving 240 MED mgs per day with Norco adding 40 mg more. With continuous pain extended-release opioids are recommended. Patients on this modality may require a dose of "rescue" opioids. The need for extra opioid can be a guide to determine the sustained release dose required. In this instance use of Norco had morphed from a rescue medication into a qid maintenance medication. Norco is considered a member of the short-acting family of opioids and as such faces a much higher risk of rebound pain and subsequent misuse. Not an appropriate use of short duration opioids. Weaning of opioid analgesics is recommended if there is no overall improvement in function, unless there are extenuating circumstances. This member was found to have had a

stable condition with no documented evidence for a sustained reduction in pain or improvement in practical function related to the use of opioids over an extended period of time despite consuming more than double the recommended maximum daily morphine equivalent dose. In the face of evidence for limited utility for improved function, recommendations for short term use of short acting opioids and the ongoing risk for rebound pain and dependence, continued use of Norco cannot be supported. The request is not medically necessary.

Retrospective request for Flexeril 10mg #30 (DOS 9/25/14): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants, Flexeril Page(s): 76.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 60, 63.

Decision rationale: The class of agents used as muscle relaxants are generally recommended for short term use only and with caution due to side effects, as second line agents for patients with exacerbations of back pain. There is no evidence that they will show a benefit beyond that of NSAID's or that there is any additional benefit in combination with NSAID's. Efficacy appears to diminish with time and maximal benefit appears to decline after approximately 4 days. Sedation is the most common class effect and needs to be considered in those having to drive or operate heavy equipment. The examination appeared to be cursory and not a part of the presenting complaint but rather a part of a continuing general complaint without evidence for an exacerbation or significant change. Based on the short-term indications for use of this class of agent in the face of the ongoing use of meloxicam, Lyrica and opioid analgesics the addition of Flexeril cannot be supported. The request is not medically necessary.