

Case Number:	CM14-0058727		
Date Assigned:	07/09/2014	Date of Injury:	11/08/1985
Decision Date:	09/10/2014	UR Denial Date:	04/23/2014
Priority:	Standard	Application Received:	04/29/2014

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 57-year-old female patient who reported an industrial injury on 11/8/1985, almost 29 years ago, attributed to the performance of her customary job tasks. The patient complains of constant lower back pain. The patient has received significant conservative care and interventional pain management injections including epidural steroid injections, SI injections, rhomboid trigger point injections, Botox injections. The patient is status post arthroscopy to the knee on 09/2014 and received opiate medications. The patient was status post laminectomy the lumbar spine. The patient has been treated with Celebrex, Zegerid, Mira lacks, Carisoprodol, Lunesta 3 mg, Norco 10/325 mg, OxyContin 80 mg nine per day, Senate cot, Cymbalta, Lidoderm patches, Lyrica 150 mg TID, Senate concentrate; Flurosemide, Levothyroxine, Metoprolol, Provigil, Simvastatin; Bupropion. The objective findings on examination included decreased range of motion to the knee and lower back along with tenderness to palpation and facet tenderness. An AME evaluation during 1989 recommended future surgery not indicated, conservative measures, MRI lumbar spine, weight reduction program, external bracing. The diagnoses included s/p lumbar laminectomy syndrome, lumbar degenerative disc disease, lumbar radiculopathy, chronic low back pain, and hip bursitis.

IMR ISSUES, DECISIONS AND RATIONALES

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

Carisoprodol 350 mg # 56: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Treatment Guidelines Page(s): 64-65.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment Page(s): 47, 128, Chronic Pain Treatment Guidelines antispasticity/anti-spasmodic drugs Page(s): 66. 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 #56 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 #56 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 without psychotropic effects are readily available. There is no medical necessity for Carisoprodol 350 mg #56. There are clearly no recommendations for the prescribed combination of Valium and Carisoprodol due to the psychotropic effects. 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 is not medically necessary. 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 without psychotropic effects are readily available. There is no medical necessity for CARISOPRODOL 350 mg #56. There are clearly no recommendations for the prescribed combination of Valium and Carisoprodol due to the psychotropic effects. 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 is not medically necessary.

Oxycontin 80 mg # 252:

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Treatment Guidelines, Opioids Page(s): 77. Decision based on Non-MTUS Citation Official Disability Guidelines-Treatment in Workers Compensation, Opioids.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300-06, 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) chapter 6 pages 114-116; Official Disability Guidelines (ODG) pain chapter opioids.

Decision rationale: The prescription for OxyContin 80 mg #252 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 29 years ago. The objective findings on examination do not support the medical necessity for continued opioid analgesics. The patient is being prescribed opioids for mechanical 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 OxyContin 80 mg #252. The patient is 29 years s/p DOI with reported continued issues. There is no demonstrated medical necessity for the continuation of opioids for the effects of the industrial injury. The chronic use of OxyContin 80 mg #252 is not recommended by the CA MTUS, the ACOEM Guidelines, or The Official Disability Guidelines for the long-term treatment of chronic back pain. 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. 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 notes, "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 OxyContin 80 mg for this long period or to support ongoing functional improvement. There is no provided evidence that the patient has received benefit or demonstrated functional improvement with the prescribed OxyContin 80 mg. There is no demonstrated medical necessity for the prescribed Opioids therefore this request is not medically necessary.

Norco 10/325 mg # 84: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Treatment Guidelines Page(s): 78-80, 91.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines opioids Page(s): 74-97. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) pain chapter-opioids.

Decision rationale: The prescription for Hydrocodone-APAP (Norco) 10/325 mg #84 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 over 29 years ago. The objective findings on examination do not support the medical necessity for continued opioid analgesics. The patient is being prescribed opioids for mechanical 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 29 years s/p DOI with reported continued issues. 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 pain. 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 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. 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 notes, 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 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 therefore this request is not medically necessary.