

Case Number:	CM14-0086445		
Date Assigned:	07/23/2014	Date of Injury:	06/03/2002
Decision Date:	10/10/2014	UR Denial Date:	05/21/2014
Priority:	Standard	Application Received:	06/09/2014

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 49-year-old female who reported an industrial injury on 6/3/2012, over 12 years ago, to the back and neck, attributed to the performance of her usual and customary job tasks reported as a lifting injury. The patient is being treated for the diagnosis of chronic neck pain; chronic bilateral hip pain; chronic left scapula/shoulder pain; chronic compensatory muscle spasm; status post anterior fusion at C5-C6. The patient complained of increasing pain to the neck, back, left scapula, and legs. The patient was reported to have radiculopathy to both legs. The patient was prescribed Vicoprofen 7.5/200 mg #180 and Soma 350 mg #90.

IMR ISSUES, DECISIONS AND RATIONALES

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

Vicoprofen 7.5/200mg Qty 180: Upheld

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

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: 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 Vicoprofen 7.5/200 mg #180 for short acting pain relief is being prescribed as an opioid analgesic for the treatment of chronic neck and upper back pain. The patient has been treated for a prolonged period time with opioids. There is no objective evidence provided to support the continued prescription of opioid analgesics for chronic mechanical neck pain 12 years after the date of injury. The patient is being continued on opioids 12 years status postdate of injury whereas he should be titrated off opioids. The chronic use of Hydrocodone is not recommended by the CA MTUS, the ACOEM Guidelines, or the Official Disability Guidelines for the long-term treatment of chronic pain only as a treatment of last resort for intractable pain. The provider has prescribed Vicoprofen 7.5/200 mg #180 for short acting opioid therapy for mechanical neck pain, upper back, and shoulder pain. The prescription of opiates on a continued long term basis is inconsistent with the CA MTUS; the Washington State Guidelines for the prescription of opioids to IWs; 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 consistent with evidence-based guidelines based on intractable pain. 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 and eye 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." Evidence-based guidelines recommend: Chronic back pain: Appears to be efficacious but limited for short-term pain relief, and long-term efficacy is unclear (>16 weeks), but also appears limited. Failure to respond to a time-limited course of opioids has led to the suggestion of reassessment and consideration of alternative therapy. There is no evidence to recommend one opioid over another. In patients taking opioids for back pain, the prevalence of lifetime substance use disorders has ranged from 36% to 56% (a statistic limited by poor study design). Limited information indicated that up to one-fourth of patients who receive opioids exhibit aberrant medication-taking behavior. The ODG states that 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, and long-range adverse effects; such as, hypogonadism and/or opioid abuse, and the influence of placebo as a variable for treatment effect. (Ballantyne, 2006) (Furlan, 2006) Long-term, observational studies have found that treatment with opioids tends to provide improvement in function and minimal risk of addiction, but many of these studies include a high dropout rate (56% in a 2004 meta-analysis). (Kalso, 2004) There is also no evidence that opioids showed long-term benefit or improvement in function when used as treatment for chronic back pain. (Martell-Annals, 2007) (ODG, Pain Chapter). There is no clinical documentation by with objective findings on examination to support the medical necessity of Hydrocodone-ibuprofen 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-Ibuprofen. There is no demonstrated medical necessity for the prescribed Opioids. The continued prescription for Vicoprofen 7.5/200 mg #180 is not demonstrated to be medically necessary.

Soma 350mg Qty 90: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disabilities Guidelines

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment Page(s): 47, Chronic Pain Treatment Guidelines antispasticity/antispasmodic drugs Page(s): 66. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) chronic pain chapter 8/8/08 page 128; Official Disability Guidelines (ODG) Pain Chapter--muscle relaxants and Carisoprodol

Decision rationale: The patient is prescribed Carisoprodol/SOMA 350 mg #90 with 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/neck 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, soma 350 mg #90 medication should be discontinued and is not medically necessary.