

<b>Case Number:</b>	CM14-0189243		
<b>Date Assigned:</b>	11/17/2014	<b>Date of Injury:</b>	04/12/2011
<b>Decision Date:</b>	01/07/2015	<b>UR Denial Date:</b>	10/14/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/10/2014

### 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 Ohio. 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 injured worker is a 52-year-old female with a date of injury of April 12, 2011. She was placing a strap on a cylinder when she felt a pop in her mid-back. After chiropractic treatment and acupuncture to return to work but on May 29, 2012 she injured her right shoulder by placing items on a shelf. She subsequently underwent arthroscopic repair of the right shoulder and had a Mumford procedure, acromioplasty, and repair of a SLAP lesion. Electrodiagnostic studies have revealed evidence of chronic bilateral C5-C6 radiculopathy and bilateral carpal tunnel syndrome. The physical examination has revealed tenderness to palpation of the cervical spine, right scapular area, right paraspinal muscles, and right trapezius. There is diminished right shoulder range of motion there is a positive Neer's test for impingement on the right side. Upper and lower extremity neurologic examination is normal per the agreed medical examiner on September 12, 2014. A thoracic epidural steroid injection had given 50% relief for 5-8 weeks back in December 2011. The diagnoses include C5-C6 radiculopathy, thoracic spine disc disease, thoracic radiculitis, lumbar disc disease without radiculopathy, and history of right shoulder labral repair. The injured worker has been treated with Tramadol since at least March 2013. Urine drug screens have been performed 5 or more times in the last 2 years and have each time been consistent with medication prescribed. It appears that Neurontin was prescribed in oral form as far back as May 17, 2012. At issue is a request for Ultram 50 mg 2 tablets twice a day, quantity unspecified, Neurontin 3 times daily, unspecified milligram amounts and quantity, daily Flexeril, unspecified milligram and quantity, and a urine drug screen request from October 24, 2014.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Ultram 50mg:** 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): 78.

**Decision rationale:** Those prescribed opioids for chronic pain require ongoing assessment of pain relief, functionality, medication side effects, and any aberrant drug taking behavior. Opioids may be continued if the injured worker has regained employment and/or if there are improvements in pain and functionality as a consequence of the medication. In this instance, the available record does not indicate if the Tramadol has been effective for pain or if there have been improvements in functional status as a consequence. Therefore, Ultram 50mg is not medically necessary.

**Neurontin:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Anti-Epilepsy Drugs (AEDs).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Anti-Epilepsy Drugs (AEDs) Page(s): 16-17.

**Decision rationale:** Anti-epilepsy drugs such as Neurontin may be used for neuropathic pain as a result of nerve damage. A "good" response to the use of AEDs has been defined as a 50% reduction in pain and a "moderate" response as a 30% reduction. It has been reported that a 30% reduction in pain is clinically important to patients and a lack of response of this magnitude may be the "trigger" for the following: (1) a switch to a different first-line agent (TCA, SNRI or AED are considered first-line treatment); or (2) combination therapy if treatment with a single drug agent fails. After initiation of treatment there should be documentation of pain relief and improvement in function as well as documentation of side effects incurred with use. The continued use of AEDs depends on improved outcomes versus tolerability of adverse effects. In this instance, there is no documentation of any kind of response to the Neurontin. The request for Neurontin does not specify milligram amounts or quantity desired. Therefore, Neurontin was not medically necessary as requested.

**Flexeril:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Cyclobenzaprine Page(s): 41-42.

**Decision rationale:** Cyclobenzaprine is a skeletal muscle relaxant and a central nervous system (CNS) depressant that is marketed as Flexeril by [REDACTED]. Flexeril is recommended as an option for pain, using a short course of therapy. Cyclobenzaprine (Flexeril) is more effective than placebo in the management of back pain; the effect is modest and comes at the price of greater adverse effects. The effect is greatest in the first 4 days of treatment, suggesting that shorter courses may be better. Treatment should be brief. There is also a post-op use. The addition of cyclobenzaprine to other agents is not recommended. In this instance, there is no quantity of Flexeril specified and therefore no way of knowing the intended length of therapy. Most guidelines limit the use of Cyclobenzaprine to 2-3 weeks. Therefore, Flexeril is not medically necessary as requested.

**Urine toxicology monitoring:** Upheld

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain (Chronic), Urine Drug Testing

**Decision rationale:** The frequency of urine drug testing should be based on documented evidence of risk stratification including use of a testing instrument. "Low risk" patients have pathology which is identifiable with objective and subjective symptoms to support a diagnosis. There is an absence of psychiatric comorbidity. The "medium risk" patient generally has objective and subjective signs and symptoms of an identifiable diagnostic problem but may have some but not all of the identifiers found under the "high risk" category. Some authors indicate that individuals with treated or non-active substance abuse issues or significant family history of this fall into this category. "High risk" patients may have psychiatric comorbidity. Minimal objective findings are documented to explain pain. Symptom magnification can be noted. Hyperalgesia may be present. Underlying pathology can include diseases associated with substance abuse including HIV, hepatitis B and C, and pathology associated with alcoholism or drug abuse. Patients with suicidal risks or poorly controlled depression may be at higher risk for intentional overdose when prescribed opioids for chronic pain. Patients at "low risk" of addiction/aberrant behavior should be tested within six months of initiation of therapy and on a yearly basis thereafter. There is no reason to perform confirmatory testing unless the test is inappropriate or there are unexpected results. In this instance, the available record does not suggest any reasons to consider this injured worker at anything but low risk terms of aberrant drug use. Her urine drug screens have been consistent with prescribed medication. There is no documentation of prior drug abuse or psychiatric pathology. She has already been drug tested twice in the calendar year. Therefore, urine toxicology monitoring per a request dated October 24, 2014 is not medically necessary.