

<b>Case Number:</b>	CM14-0191713		
<b>Date Assigned:</b>	11/25/2014	<b>Date of Injury:</b>	05/28/2004
<b>Decision Date:</b>	01/12/2015	<b>UR Denial Date:</b>	10/29/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/17/2014

### 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:

This 67 year old female sustained a work related injury on May 28, 2004. According to Utilization Review, the injury occurred with a branch caught her pant leg causing her to fall to her knees and hands. According to a progress report dated 09/29/2014, the injured worker complained of pain in the cervical and lumbar spine. Cervical spine pain radiated to her arms causing numbness and tingling in both arms. Lumbar spine pain radiated down both the lower extremities with numbness and tingling noted. Cervical spine pain was worse and radiated to the head and shoulder as well as caused headaches. Bilateral hand pain was somewhat diminished with medications and compound creams. Current medications included Fexmid, Fioricet, Norco 10, Prilosec, Ultram ER and Flurbiprofen/Menthol/Capsaicin topical cream. Physical examination of the cervical spine revealed tenderness to palpation in the cervical paraspinal musculature and bilateral upper trapezius muscles. There was decreased range of motion secondary to pain and stiffness. Spurling's sign was positive bilaterally. Examination of the bilateral hands revealed well-healed incisions. Tinel's and Phalen's signs were negative. Examination of the lumbar spine revealed tenderness to palpation in the lumbar paraspinal musculature. There was decreased range of motion secondary to pain and stiffness. Straight leg raise test was positive at 20 degrees in the bilateral lower extremities. Neurological examination revealed motor strength was 5/5 in the bilateral upper and lower extremities. There was normal bulk and tone. Sensory examination was intact to light touch and pin prick. Reflexes were 2+ throughout. Both toes were down going. Diagnoses included carpal tunnel syndrome, cervical discopathy with disc displacement, cervical radiculopathy, lumbar discopathy with disc displacement and lumbar radiculopathy. Plan of care included continuation of medications for symptomatic relief of pain and headaches and compound creams to help with the muscles spasms and pain control. Medications that were prescribed included Fexmid, Norco, Prilosec, Ultram

ER and Flurbiprofen/Menthol/ Camphor/Capsaicin topical cream. Authorization was requested for a urine toxicology test to assist in monitoring adherence to a prescription drug treatment regimen, to diagnose substance misuse/abuse, addiction and/or other aberrant drug related behavior to guide treatment and to advocate for patients. The injured worker was temporarily totally disabled and instructed to remain off work. She was to follow up in 4 to 6 weeks. There were no previous laboratory tests submitted for review. On 10/29/2014 Utilization Review, non-certified Cyclobenzaprine 7.5mg #120, Norco 10/325mg #120, Ultram ER 150mg #90, urine toxicology screen and modified Prilosec 20mg #90 that was requested. The request was received on 10/22/2014. According to the Utilization Review physician in regards to Cyclobenzaprine there was no explicit documentation of spasm relief from this medication and there was insufficient documentation contraindicating the use of non-steroidal anti-inflammatories for the injured worker's current condition. In regards to Norco, MTUS guidelines recommend continued use of this opiate for the treatment of moderate to severe pain with documented objective evidence of derived functional benefit. There was no documented function improvement from previous usage. On 06/02/2014 the request for this medication was modified to initiate a weaning process. In regards to Prilosec, the injured worker is being prescribed opiates with acetaminophen which carries an inherent risk for gastrointestinal issues. The request for Prilosec was modified to comply with referenced guidelines of once daily dosage recommendations. In regards to Ultram ER, MTUS guidelines recommend continued use of this opiate for the treatment of moderate to severe pain with documented objective evidence of derived functional benefit. There was no documented function improvement from previous usage. On 06/02/2014 the request for this medication was modified to initiate a weaning process. In regards to a urine toxicology screen, there was no documentation of provider concerns over the use of illicit drugs or non-compliance with prescription medication. There was no documentation of the dates of previous drug screenings over the past 12 months or what those results were and any potential related actions taken. This decision was appealed for an Independent Medical Review.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**Prilosec 20mg #90:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS, GI Symptoms and Cardiovascular Risk Page(s): 68-69.

**Decision rationale:** Per the Chronic Pain Medical Treatment Guidelines, page 68, NSAIDs, GI symptoms & cardiovascular risk: Recommend with precautions as indicated below. Clinicians should weight the indications for NSAIDs against both GI and cardiovascular risk factors. Determine if the patient is at risk for gastrointestinal events: (1) age > 65 years; (2) history of peptic ulcer, GI bleeding or perforation; (3) concurrent use of ASA, corticosteroids, and/or an anticoagulant; or (4) high dose/multiple NSAID (e.g., NSAID + low-dose ASA). Recent studies tend to show that H. Pylori does not act synergistically with NSAIDS to develop gastroduodenal lesions. Recommendations: Patients with no risk factor and no cardiovascular disease: Non-

selective NSAIDs OK (e.g., ibuprofen, naproxen, etc.). Patients at intermediate risk for gastrointestinal events and no cardiovascular disease: (1) A non-selective NSAID with either a PPI (Proton Pump Inhibitor, for example, 20 mg omeprazole daily) or misoprostol (200 g four times daily) or (2) a Cox-2 selective agent. Long-term PPI use (> 1 year) has been shown to increase the risk of hip fracture (adjusted odds ratio 1.44). Patients at high risk for gastrointestinal events with no cardiovascular disease: A Cox-2 selective agent plus a PPI if absolutely necessary. Patients at high risk of gastrointestinal events with cardiovascular disease: If GI risk is high the suggestion is for a low-dose Cox-2 plus low dose Aspirin (for cardioprotection) and a PPI. The injury occurred more than 10 years ago. She fell on her hands and knees. Although she is now 67 years old, there is no history of peptic ulcer disease or GI bleed and NSAIDs are to be discontinued. There was no objective functional improvement with NSAIDs. There is insufficient documentation to substantiate the medical necessity of continued PPI treatment. Therefore, the request is not medically necessary.

**Cyclobenzaprine 7.5mg #120:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants for Pain Page(s): 64-66.

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

**Decision rationale:** Per the Chronic Pain Medical Treatment Guidelines, 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) The injury occurred more than 10 years ago when she fell on her hands and knees. There was no objective documented functional improvement with the use of muscle relaxants in this patient. Continued long term use of muscle relaxants is not consistent with MTUS guidelines. Therefore, the request is not medically necessary.

**Norco 10/325mg #120:** 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 Opioids On-Going Management Page(s): 78-79.

**Decision rationale:** Per the Chronic Pain Medical Treatment Guidelines, page 78: 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. There was no objective documentation of functional improvement with the use of opiates in this patient who fell more than 10 years ago. Also, there is no documentation that the above criteria for on-going opiate management were met. Therefore, the request is not medically necessary.

**Ultram ER 150mg #90:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Tramadol (Ultram) Page(s): 93-94.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids On-Going Management Page(s): 78-79.

**Decision rationale:** Per the Chronic Pain Medical Treatment Guidelines, page 78: 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. The injury/fall to her hands and knees occurred more than 10 years ago. There is no objective documentation that the use of opiates in this patient provided any objective functional benefit. Also, the above criteria for on-going opiate treatment were not met. Therefore, the request is not medically necessary.

**Urine tox screen:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Urine Drug Screen Page(s): 43.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Drug Testing Page(s): 43.

**Decision rationale:** Per guidelines: recommended as an option, using a urine drug screen to assess for the use or the presence of illegal drugs. This might be recommended at the initial stage of treatment for this injury that occurred more than 10 years ago. However, at this point, the patient is 67 years old and there is no objective documentation or history of illegal drug use/abuse. There is no documentation of any drug related aberrant behavior. Therefore, the request is not medically necessary.

