MAXIMUS Federal Services

Case Number:	CM14-0197469		
Date Assigned:	12/05/2014	Date of Injury:	08/11/1999
Decision Date:	01/22/2015	UR Denial Date:	11/18/2014
Priority:	Standard	Application Received:	11/24/2014

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 Practice 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 3-year-old female with a good injury of August 11, 1999. She injured her back and neck while shoveling sludge into a wheelbarrow. The diagnoses include cervical disc disease, polysubstance drug abuse in remission, lumbosacral radiculopathy, depression, sleep apnea, diabetes with peripheral neuropathy, cervicalgia, panic disorder without agoraphobia, and somatoform disorder. She has been dependent upon opiates for several years as well as Benzodiazepines. The physical examination reveals diminished cervical range of motion, a negative Spurling's maneuver, tenderness to palpation of the paraspinal cervical musculature, and diminished sensation in the C7 region. There is tenderness to palpation of the lumbar paraspinal musculature with a normal lower extremity neurologic exam. She has been taking Soma 350 mg 3 times daily for muscle spasm it is said during the day and lorazepam 0.5 mg for muscle spasm in the evening, however that medication is also written to be taken 3 times daily as needed. She had been utilizing a Duragesic patch for pain relief but that was discontinued. She continues to use oxycodone 15 mg 4 times daily for severe pain in addition to Norco 3 times daily for moderate pain. On April 24, 2014 it is said that her pain levels were 4/10 with pain medication and 9/10 without pain medication although pain scores after this date are relatively rare. This combination of medication also is said to optimize the patient's functionality in terms of activities of daily living although specific examples are not provided. A November 11, 2014 the injured worker had a flair-up of upper extremity pain after lifting a gallon of water consequently a Medrol dose pack was prescribed. At issue are requests for oxycodone 15 mg, #100, Medrol dose pack, lorazepam 0.5 mg, #75, and Soma 350 mg #90. The oxycodone and lorazepam have been noncertified on a couple of occasions with modified quantities being allowed for weaning purposes. The Soma has been noncertified altogether.

IMR ISSUES, DECISIONS AND RATIONALES

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

Lorazepam 0.5mg #75: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines Page(s): 24.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines Page(s): 24.

Decision rationale: Benzodiazepines are not recommended for long-term use because long-term efficacy is unproven and there is a risk of dependence. Most guidelines limit use to 4 weeks. Their range of action includes sedative/hypnotic, anxiolytic, anticonvulsant, and muscle relaxant. Chronic benzodiazepines are the treatment of choice in very few conditions. Tolerance to hypnotic effects develops rapidly. Tolerance to anxiolytic effects occurs within months and long-term use may actually increase anxiety. Tolerance to anticonvulsant and muscle relaxant effects occurs within weeks. In this instance, the lorazepam has been in use for over one year. The treating physician states that the lorazepam has been used in the evenings for muscle spasms; however, the prescription continues to be for 3 times daily dosing as needed and therefore, the actual indication for use here is vague. The previous utilization review suggested medication weaning and provided a modified medication quantity for that. Therefore, Lorazepam 0.5mg #75 is not medically necessary.

Medrol 4mg #1: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG); Oral corticosteroids www.drugs.com; Physician's Desk Reference (PDR), (2014)

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back, Corticosteroids (oral/parenteral/IM for low back pain)

Decision rationale: Per guidelines, Criteria for the Use of Corticosteroids (oral/parenteral for low back pain): (1) Patients should have clear-cut signs and symptoms of radiculopathy; (2) Risks of steroids should be discussed with the patient and documented in the record; (3) The patient should be aware of the evidence that research provides limited evidence of effect with this medication and this should be documented in the record; (4) Current research indicates early treatment is most successful; treatment in the chronic phase of injury should generally be after a symptom-free period with subsequent exacerbation or when there is evidence of a new injury. In this instance, there is no evidence that the treating physician notify the patient regarding the risks of steroids and that the evidence for effectiveness of this medication is limited. Consequently, all of the criteria necessary for the use of corticosteroids for acute radiculopathy were not satisfied. Therefore, the request is not medically necessary per the referenced guidelines.

Oxycodone 15mg #100: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74-97.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74-96. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain (Chronic), Opioids, long-term assessment

Decision rationale: Per guidelines, those prescribed opiates chronically should have ongoing assessment for pain relief, functionality, medication side effects, and any aberrant drug taking behavior. Monitoring for aberrant drug taking behavior takes the form of urine drug testing and inquiries into pharmacy databases such as CURES. Those at moderate risk for aberrant drug taking behavior include those with comorbid psychiatric diagnoses. Those at moderate risk for aberrant drug taking behavior should have urine drug screening 2 or 3 times yearly. Before initiating opioid therapy there should be baseline pain and functional assessments. Function should include social, physical, psychological, daily and work activities, and should be performed using a validated instrument or numerical rating scale. Functional improvement measures are recommended. The importance of an assessment is to have a measure that can be used repeatedly over the course of treatment to demonstrate improvement of function, or maintenance of function that would otherwise deteriorate. It should include the following categories: Work Functions and/or Activities of Daily Living, Self-Report of Disability (e.g., walking, driving, keyboard or lifting tolerance, Oswestry, pain scales, etc.): Objective measures of the patient's functional performance in the clinic (e.g., able to lift 10 lbs. floor to waist x 5 repetitions) are preferred, but this may include self-report of functional tolerance and can document the patient self-assessment of functional status through the use of questionnaires, pain scales, etc. (Oswestry, DASH, VAS, etc.) Physical Impairments (e.g., joint ROM, muscle flexibility, strength, or endurance deficits): Include objective measures of clinical exam findings. ROM should be in documented in degrees. Approach to Self-Care and Education Reduced Reliance on Other Treatments, Modalities, or Medications: This includes the provider's assessment of the patient compliance with a home program and motivation. The provider should also indicate a progression of care with increased active interventions (vs. passive interventions) and reduction in frequency of treatment over course of care. (California, 2007) For chronic pain, also consider return to normal quality of life, e.g., go to work/volunteer each day; normal daily activities each day; have a social life outside of work; take an active part in family life. Pain should be assessed at each visit, and functioning should be measured at 6-month intervals using a numerical scale or validated instrument. In this instance, the treating physician states that as a consequence of the medication regimen, the level of function in terms of activities of daily living has been optimized. No formal assessment for functional improvement has occurred where has been submitted within the nearly 600 documents available for review. Additionally, the screening for aberrant drug taking behavior, based upon submitted documentation, has been inadequate. One urine drug screen appears notes from April 24, 2014 and that does not reveal evidence of prescribed medication which is therefore an inconsistent result. No subsequent urine drug screens appear in the record. There is no mention of pharmacy database inquiries. Consequently, the medical necessity for oxycodone 15 mg, #100, has not been established per the referenced guidelines and is therefore is not medically necessary. The reduced quantity of

oxycodone has previously been provided for purposes of weaning. The request is not medically necessary.

Soma 350mg #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxant Page(s): 29.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants for pain Page(s): 63 and 65.

Decision rationale: The MTUS recommends non-sedating muscle relaxants with caution as a second-line option for short-term treatment of acute exacerbations in patients with chronic LBP (low back pain). 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. Sedation is the most commonly reported adverse effect of muscle relaxant medications. Carisoprodol (Soma, Soprodal 350, Vanadom, generic available): Neither of these formulations is recommended for longer than a 2 to 3 week period. Carisoprodol is metabolized to meprobamate an anixolytic that is a schedule IV controlled substance. Carisoprodol is classified as a schedule IV drug in several states but not on a federal level. It is suggested that its main effect is due to generalized sedation as well as treatment of anxiety. This drug was approved for marketing before the FDA required clinical studies to prove safety and efficacy. Withdrawal symptoms may occur with abrupt discontinuation. In this instance, Soma has been in continuous use for several months if not longer. The use of this product is therefore no longer medically appropriate per the referenced guidelines. Hence, Soma 350mg #90 is not medically necessary.