MAXIMUS Federal Services

Case Number:	CM14-0205356		
Date Assigned:	12/17/2014	Date of Injury:	01/10/2010
Decision Date:	02/09/2015	UR Denial Date:	11/14/2014
Priority:	Standard	Application Received:	12/08/2014

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 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 man of unknown age reported an injury with a date of 1/10/10. The mechanism of injury is not described in the available records, nor is the course of treatment. The records contain three progress notes from the current primary treater's office, ranging from 6/17/14 to 10/23/14, all signed by a physician's assistant. All of them document that the patient has pain in the left mid-back. Functional status and work status are never documented. Documented physical findings are minimal, and include tenderness of the left T11 costovertebral joint. The patient walks with a cane. Diagnosis is left T11 rib pain, status post subluxation. For all three visits, the treatment plan includes providing the patient with Norco 10/325 BID, Cyclobenzaprine 10 mg BID, tramadol 50 mg 2 tablets TID, and Valium 10 mg BID. No rationale is documented for any of the medications. The plan on 8/28/14 includes a statement that "we will work on tapering them (the medications) in the future". No such tapering has occurred. No functional goals are ever discussed, and no more active form of treatment is ever prescribed. Requests for Norco 10/325 #60, tramadol 50mg #180 with one refill, Valium 10 mg #60 with one refill and cyclobenzaprine 10 mg #60 with one refill were non-certified in UR on 1/14/14 based on MTUS Chronic Pain Guidelines.

IMR ISSUES, DECISIONS AND RATIONALES

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

Norco 10/325MG #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines opioids Page(s): 91.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Medications for Chronic Pain; Criteria for Use of Opioids, Steps to Take Before a Therapeutic Tr.

Decision rationale: Norco 10/325 is brand-name hydrocodone 10 mg with acetaminophen 325 mg. Hydrocodone is an opioid analgesic. Per the MTUS recommendations cited above, medications should be trialed one at a time while other treatments are held constant, with careful assessment of function, and there should be functional improvement with each medication in order to continue it. Opioids should not be started without an evaluation of the patient's current status in terms of pain control and function. An attempt should be made to determine if the patient's pain is nociceptive or neuropathic. Red flags indicating that opioid use may not be helpful should be identified, as should risk factors for abuse. Opioids should be discontinued if there is no improvement in function. There is no good evidence that opioids are effective for radicular pain. If long-term use of opioids occurs, there is a need for ongoing pain and function assessments, as well as assessments for side effects, of concurrent other treatments, and of concurrent psychological issues. The clinical findings in this case do not demonstrate that any of the above guidelines have been followed. This patient has been prescribed Norco since at least 6/17/14. There is no documentation of evaluation of whether or not the patient's pain is nociceptive or neuropathic. No assessment is documented of whether or not opioid use was likely to be helpful in this patient, or of his potential for abuse. There is no documentation of any functional goals for the use of opioids. Since the treating provider does not bother to document a work status or any functional assessment, it is impossible to tell if the patient has made any functional progress, but it seems likely that he has not. He is on so many sedating medications that it is very unlikely that he is working. Based on the MTUS citations above and on the clinical documentation provided for my review, Norco 10/325 #60 is not medically necessary. It is not medically necessary because there is no documentation of an appropriate assessment prior to beginning it, because of the failure to set and monitor functional goals for its use, and because it appears to be highly unlikely that the patient has made any functional progress while taking it.

Tramadol 50mg #180 with 1 refill: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Medications for Chronic Pain; Criteria for use of Opioids; Steps to Take Before a Therapeutic Tr. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: UptoDate, an online evidence-based review service for clinicians (www.uptodate.com), Tramadol: Drug Information.

Decision rationale: Tramadol is and opioid medication and therefore falls under guidelines for medications in general and for opioids specifically. According to the first MTUS guideline cited above, medications should be started individually while other treatments are held constant, with

careful assessment of function. There should be functional improvement with each medication in order to continue it. The remaining MTUS guidelines state that opioids should not be started without an evaluation of the patient's current status in terms of pain control and function. An attempt should be made to determine in the patient's pain is nociceptive or neuropathic. Red flags indicating that opioid use may not be helpful should be identified, as should risk factors for abuse. Specific goals should be set, and continued use of opioids should be contingent on meeting these goals. Opioids should be discontinued if there is no improvement in function or if there is a decrease in function. Per the UptoDate reference cited above, tramadol increases the risk of seizures even at recommended doses in patients who have not previously had seizures. This risk is increased in patients on other opioids or cyclobenzaprine. The clinical findings in this case do not support the use of tramadol for this patient. Tramadol is being prescribed in conjunction with cyclobenzaprine and with another opioid, which increases the patient's risk for seizure. There is no documentation of evaluation of whether or not the patient's pain is nociceptive or neuropathic. No assessment was made of whether or not opioid use was likely to be helpful in this patient, or of his potential for abuse. There is no documentation of any functional goals for the use of opioids. Since the treating provider does not bother to document a work status or any functional assessment, it is impossible to tell if the patient has made any functional progress, but it seems likely that he has not. He is on so many sedating medications that it is very unlikely that he is working. Based on the evidence-based citations above and on the clinical documentation provided for my review, tramadol 50 mg #180 with one refill is not medically necessary. It is not medically necessary because it increases the patient's likelihood of having a seizure, particular when combined with cyclobenzaprine and Norco, because there is no documentation of an appropriate assessment prior to beginning it, because of the failure to set and monitor functional goals, and because it appears to be highly unlikely that the patient has made any functional progress while taking it.

Valium 10mg #60 with 1 refill: 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 Medications for Chronic Pain; Benzodiazepines Page(s): 60,24. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: UptoDate. an online evidence-based review service for clinicians, (www.uptodate.com), Diazepam: Drug information.

Decision rationale: Valium is brand-name diazepam, which is a benzodiazepine. According to the MTUS references above, medications should be trialed one at a time while other treatments are held constant, with careful assessment of function, and there should be functional improvement with each medication in order to continue it. 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. A more appropriate treatment for anxiety is an antidepressant. Tolerance to anticonvulsant and muscle relaxant effects occurs within weeks. According to the UptoDate reference, significant side effects of Valium include confusion, depression, drowsiness, fatigue, sleep disturbance and insomnia. Valium should be used with caution in patients who are depressed, especially if they are at risk for suicide. Valium should be used with caution in patients receiving other CNS depressants due the potential for increased sedation, and CNS depression. Opioid use should be decreased by approximately one third when the patient is taking Valium. The clinical findings in this case do not support the continued use of Valium. This patient has been taking it for months and possibly years in conjunction with multiple other potentially addictive CNS depressants. He has had no documented functional progress due to taking Valium. This patient continues to take high doses of two opioids in addition to Valium and cyclobenzaprine. It appears likely that Valium may be interfering with any possible recovery in this case. Taking into consideration the evidence-based citations above and the clinical findings in this case, Valium 10 mg #60 with one refill is not medically necessary. It is not necessary because its long-term use is not indicated, because its use has not resulted in any functional recovery for this patient, and because it actually may be contributing to his current ongoing disability.

Cyclobenzaprine 10mg #60 with 1 refill: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines muscle relaxants Page(s): 63-64.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Medications for Chronic Pain; Muscle relaxants Page(s): 60,63-66. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: UptoDate, an online evidence-based review service for clinicians (www.uptodate.com), Tramadol: Drug Information.

Decision rationale: Cyclobenzaprine is a sedating muscle relaxant. Per the first reference cited above, medications should be trialed one at a time while other treatments are held constant, with careful assessment of function, and there should be functional improvement with each medication in order to continue it. Per the second reference, non-sedating muscle relaxants are recommended with caution as a second-line option for short-term treatment of acute exacerbations in patients with chronic low back pain. In most low back pain patients, they show no benefit. There is no additional benefit if they are used in combination with NSAIDs. Efficacy appears to diminish over time. Cyclobenzaprine is only recommended for a short course of therapy, as there is no evidence to support its long-term use. Its greatest effect appears to occur within the first four days of treatment. Side effects include drowsiness, urinary retention, dry mouth and headaches. Its use should be avoided in patients with arrhythmias, heart block, heart failure and recent myocardial infarction. Per the UptoDate reference cited above, tramadol increases the risk of seizures even at recommended doses in patients who have not previously had seizures. This risk is increased in patients on other opioids or cyclobenzaprine. The clinical documentation in this case does not support the use of cyclobenzaprine. The patient has been taking cyclobenzaprine for at least 4 months, which would mean that any current muscle spasm he is experiencing would not be acute. The prescription for cyclobenzaprine clearly extends

beyond the four days that it is likely to be effective. The use of cyclobenzaprine combined with tramadol puts this patient at increased risk for seizure. There is no documentation that this patient has made any functional improvement while taking cyclobenzaprine. Finally, cyclobenzaprine is sedating, particularly when combined with two opioids and Valium. It actually may make it more difficult for this patient to increase his level of activity and thus interfere with his recovery. Based on the evidence-based citations above and on the clinical records provided for my review, cyclobenzaprine 10 mg #60 with one refill is not medically necessary. It is not medically necessary because there is no evidence to support its long-term use, because it increases the risk of seizure when combined with tramadol and opioids, because there is no documentation of any functional recovery due to its use, and because its side effects may in fact be interfering with this patient's recovery.