

Case Number:	CM14-0208524		
Date Assigned:	12/22/2014	Date of Injury:	05/17/2011
Decision Date:	02/17/2015	UR Denial Date:	11/18/2014
Priority:	Standard	Application Received:	12/12/2014

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 44-year old office assistant reported injuries to her right shoulder, arm, elbow, wrist and hand as well as to her left ankle due to a near fall while descending stairs on 5/17/11. Treatment has included right carpal tunnel release, right elbow surgery, chiropractic manipulation, and physical therapy. Her current primary treater is a chiropractor. She is also followed by a pain management specialist and by an orthopedist. The pain management specialist saw this patient for the first time on 10/2/14. She complained of severe neck pain radiating down her right shoulder to her hand and fingers, with weakness, numbness and tingling. She was taking no medications. She had been on total disability status since 7/7/13. Notable exam findings included obesity (BMI 35.5), tenderness of the neck, decreased range of neck motion with positive right Spurling's sign, decreased right shoulder range of motion with positive impingement signs, weakness of the right shoulder and elbow, and decreased sensation in a right C5-C7 distribution. Diagnoses included cervical disc disease and radiculopathy, right shoulder impingement syndrome, and status post carpal tunnel release. Plan included reviewing the patient's cervical MRI and EMG/NCV of the upper extremities, and possible epidural steroid injections. The provider apparently dispensed ibuprofen 800 mg one twice per day #60, Norco 10/325 one every 4-6 hours #120, and Fexmid 7.5 mg one three times per day, "as a muscle relaxant. She should be treated for up to three months only." A "random" urine drug screen was collected "to establish a baseline, ensure compliance of medications and ensure that he is not taking medication from multiple sources of illicit drugs". At a follow-up visit 10/16/14, the same provider noted that he had reviewed the patient's cervical MRI and that it showed a posterior annular tear at C6-7 with a 2.5 mm central disc protrusion. He stated that the patient had decreased sensation in the right C7 dermatome, and requested authorization for a right C5-6 epidural steroid injection. The provider apparently submitted a request for authorization for the

epidural steroid injection, and for the ibuprofen, Norco, Fexmid and urine drug screen on 11/11/14. The request for authorization is not available in the records. The epidural steroid injection was approved in UR on 11/18/14, as was the ibuprofen. The epidural steroid injection was performed on 11/27/14. The Norco, Fexmid and urine drug screen were all denied on 11/11/14. MTUS Chronic Pain Guidelines were quoted extensively as the basis for all three denials. The requesting provider wrote letters of appeal of the denials dated 11/22/14 and 11/23/14. The letter concerning the urine drug screen stated that pharmacologic treatment is the mainstay of the patient's regimen, and that it is only prudent to request drug screening in order to monitor drug compliance and detect possible misuse or abuse. The letter is obviously templated, since it states that the patient is currently using Norco and Fexmid to address his injuries. It gives an additional rationale that urine drug screening is indicated to evaluate kidney function. The appeal letter regarding Norco and Fexmid states that the patient has persistent chronic pain which has not been responsive to other treatment modalities, that Norco was prescribed over other analgesics due to its lack of gastrointestinal side effects, and that Fexmid was prescribed to decrease spasm and pain levels, and that both medications were prescribed with the intention of facilitating the patient's functional recovery.

IMR ISSUES, DECISIONS AND RATIONALES

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

Urine toxicology screening: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Criteria for Use, Therapeutic Trial of Opioids; Opioids, Ongoing Management; Opioids, S. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Section, Urine Drug Testing, criteria for use.

Decision rationale: Per the MTUS guidelines cited above, an assessment of the likelihood for substance abuse should be made before a therapeutic trial of opioid use is begun. The section on ongoing management of opioid use recommends that regular assessment for aberrant drug taking behavior should be performed. Drug screens should be used in patients with issues of abuse, addiction or poor pain control. The section on steps to avoid misuse/addiction recommends frequent random urine toxicology screens. Per the ODG reference cited, clinicians should be clear on the indication for using a UDS prior to ordering one. Testing frequency should be determined by assessing the patient's risk for misuse, with low-risk patients to receive random testing no more than twice per year. Documentation of the reasoning for testing frequency, need for confirmatory testing, and of risk assessment is particularly important in stable patients with no evidence of risk factors or previous aberrant drug behavior. Standard drug classes should be included in the testing, including cocaine, amphetamines, opiates, oxycodone, methadone, marijuana, and benzodiazepines. Others may be tested as indicated. A complete list of all drugs the patient is taking, including OTC and herbal preparations must be included in the request accompanying the test, as well as documentation of the last time of use of specific drugs evaluated for. Random collection is preferred. Unexpected results (illicit drugs, scheduled drugs

that were not prescribed, or negative results for a prescribed drug) should be verified with GCMS. The clinical documentation in this case does not support the performance of a urine drug screen on this patient. She appears to be at low risk for substance abuse and aberrant behavior, as is noted more than once by the requesting provider in his appeal letter. Since the patient was not actually taking any medications at the time that it was collected, the argument made by the provider that it was collected to monitor compliance with her prescribed medications is specious. If the provider is truly concerned about the possibility that the patient is using illicit drugs, a random urine drug screen should have been performed. A drug screen performed in a provider's office on the date of a clinical visit is by definition not random. Based on the evidence-based citations above and on the clinical information provided for my review, a urine drug screen was not medically necessary in this case.

Norco 10/325 mg QTY: 120.00: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 76-80, 91, and 124.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Medications for Chronic Pain; Criteria for use of Opioids; Opioids for neuropathic pain Page(s).

Decision rationale: Norco 10/325 is brand-name hydrocodone 10 mg with 325 mg acetaminophen. Hydrocodone is an opioid analgesic. According to the first 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 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 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. A therapeutic trial of opioids should not be employed until the patient has failed a trial of non-opioid analgesics. Specific functional 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. Opioids are not recommended as first-line therapy for neuropathic pain. The response of neuropathic pain to drugs may depend on the cause of the pain. There are very limited numbers of studies that involve opioid treatment for chronic lumbar root pain. A recent study found that chronic radicular lumbar pain did not respond to opioids in doses that have been effective for painful diabetic neuropathy and postherpetic neuralgia. The clinical documentation in this case does not support the provision of Norco 10/325 to this patient. Two other medications were started at the same time as Norco (ibuprofen and Fexmid), which makes it impossible to determine which of the medications caused any improvement in pain or function as well as any side effect that occurs. There is no clear documented assessment of the patient's pain, of red flags indicating that opioid use may not be helpful, or of the patient's functional status and goals. There is no documentation of a trial of non-opioid analgesics. Since this patient's diagnoses included cervical radiculopathy and status post carpal tunnel release, it seems quite likely that much of her pain is neuropathic and may not respond well to opioids. Based on the MTUS citations above and on the clinical documentation provided for my review, Norco 10/325 # 120 is not medically necessary. It is not medically necessary because it was

started simultaneously with two other medications, because an appropriate assessment of the patient's pain and function levels were not documented prior to beginning it, because there is no documentation of a trial of non-opioid analgesics, because the patient's pain appears likely to be neuropathic (which would mean that an opioid is not a first-line drug for it), and because no functional goals were set for the use of Norco.

Fexmid 7.5 mg QTY: 90.00: 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 rationale: Fexmid 7.5 mg is a long-acting form of cyclobenzaprine, which 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. The clinical documentation in this case does not support the use of Fexmid. It is being started at the same time as ibuprofen and Norco, which means that it is impossible to determine which medication is causing any beneficial or adverse effect that occurs. This patient has chronic neck pain without documentation of a recent exacerbating event, which makes it unlikely that any spasm she is experiencing is acute. The prescription for Fexmid clearly extends beyond the four days that it is likely to be effective. Finally, Fexmid is long-acting and sedating, particularly when combined with an opioid such as Norco. Based on the MTUS citations above and on the clinical records provided for my review, Fexmid 7.5 mg #90 is not medically necessary in this case because it is being started with two other drugs, because there is no evidence to support its short or long-term use, and because its side effects may in fact interfere with this patient's recovery.