

Case Number:	CM14-0060742		
Date Assigned:	07/09/2014	Date of Injury:	03/25/2001
Decision Date:	04/13/2015	UR Denial Date:	04/29/2014
Priority:	Standard	Application Received:	05/01/2014

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
 State(s) of Licensure: Pennsylvania
 Certification(s)/Specialty: Internal Medicine

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 following clinical case summary was developed based on a review of the case file, including all medical records: The injured worker is a 53 year old female who sustained an industrial injury on 03/25/2001. Diagnoses include depression, chronic pain, depressive psychosis, malaise and fatigue, and generalized osteoarthritis. Prior treatments include transcutaneous electrical nerve stimulation (TENS) unit, medications, chiropractic treatment, viscosupplementation injections to the knee, and arthroscopic right knee surgery. An Agreed Medical Examination (AME) on 6/29/09 noted that the injured worker medically retired in January of 2003. Work status was not otherwise addressed. The AME discussed diagnoses of lumbosacral strain, cervicothoracic strain, and chronic myofascial disorder. Avinza (morphine), hydrocodone (norco), zanaflex (tizanidine), and Zoloft (sertraline) have been prescribed since 2009. Diclofenac has been prescribed since at least May of 2013. More recent progress notes from May 2013 through April 2014 note continued use of avinza, zanaflex, Zoloft, diclofenac, norco, and amitriptyline. In January of 2014, the physician documented that the injured workers quality of life was improved on medications, that there were no side effects of medications, and that the injured worker does not abuse or share the medications. Minimal physical examination findings were documented in more recent progress notes. Progress note from March 2014 noted reduced shoulder range of motion and appropriate mood and affect. No detailed examination of the back was provided in the 2013 and 2014 progress notes. Recorded blood pressure readings were normal. A follow up visit dated 04/23/2014 noted the injured worker had chronic pain. The documentation notes that the physician prescribed Avinza, Hydrocodone, Tizanidine, Diclofenac, and Sertraline which

allow the patient the ability to perform activities and function in life although she still has pain even with the medications. Avinza was noted to provide limited relief from chronic back pain and allows her to walk, bend, lift, and carry within limitations. The hydrocodone was noted to allow the injured worker to continue with housework, yard work, and babysitting. Tizanidine was noted to ease back muscle spasms and allow the injured worker to have more mobility and flexibility with less pain and the ability to perform household functions. Diclofenac was noted to allow more fluidity in motion. Sertraline was noted to ease stresses created by chronic pain and that without it she was very limited in interpersonal activities. The physician documented that the injured worker was taking the medications as prescribed with no side effects or ill effects and requires this medication regimen to maintain some function. A request was made for Diclofenac 75 mg, Hydrocodone/APAP 7.5/325mg, Morphine Sulfate ER 20mg, Tizanidine 4mg, and Sertraline 50 mg. The request for authorization dated 4/11/14 notes that hydrocodone/acetaminophen was prescribed for chronic pain, tizanidine for muscle spasm, sertraline for depression, and diclofenac for arthritis. On 04/29/2014, Utilization Review, non-certified the requests, citing the MTUS, ACOEM, and Occupational Medicine Practice Guidelines Plus, On 05/01/2014, the injured worker submitted an application for independent medical review of services requested.

IMR ISSUES, DECISIONS AND RATIONALES

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

Diclofenac 75mg #240: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS Page(s): 67-73.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS Page(s): 67-73.

Decision rationale: The injured worker has been prescribed diclofenac for at least 11 months for chronic back pain. Per the MTUS, nonsteroidal anti-inflammatory drugs (NSAIDs) are recommended as a second line treatment after acetaminophen for treatment of acute exacerbations of chronic back pain. The MTUS does not specifically reference the use of NSAIDs for long term treatment of chronic pain in other specific body parts. NSAIDs are noted to have adverse effects including gastrointestinal side effects and increased cardiovascular risk; besides these well-documented side effects of NSAIDs, NSAIDs have been shown to possibly delay and hamper healing in all the soft tissues including muscles, ligaments, tendons, and cartilage. NSAIDs can increase blood pressure and may cause fluid retention, edema, and congestive heart failure; all NSAIDS are relatively contraindicated in patients with renal insufficiency, congestive heart failure, or volume excess. They are recommended at the lowest dose for the shortest possible period in patients with moderate to severe pain. The MTUS does not recommend chronic NSAIDs for low back pain; NSAIDs should be used for the short term only. Systemic toxicity is possible with NSAIDs. The FDA and MTUS recommend monitoring of blood tests and blood pressure. There is no evidence that the prescribing physician is adequately monitoring for toxicity as recommended by the FDA and MTUS. Recorded blood pressure readings were normal; however, there was no documentation of laboratory monitoring.

There was no documentation of functional improvement as a result of use of this medication. Work status was not discussed other than notation at the AME in 2009 that the injured worker was medically retired. Some activities of daily living were noted to be improved with other medications; however the discussion of diclofenac noted only more fluidity in motion. There were no decrease in medication use and office visits continued at the same frequency. Due to length of use not in accordance with the guidelines, and lack of functional improvement, the request for diclofenac is not medically necessary.

Hydrocodone/Acetaminophen 7.5/325mg #480: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 89.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines opioids Page(s): 74-96.

Decision rationale: The injured worker has been prescribed morphine and hydrocodone for at least 11 months and possibly as long as 5 years. There is no evidence that the treating physician is prescribing opioids according to the MTUS, which recommends prescribing according to function, with specific functional goals, return to work, random drug testing, and opioid contract. There should be a prior failure of non-opioid therapy. None of these aspects of prescribing are in evidence. Per the MTUS, opioids are minimally indicated, if at all, for chronic non-specific pain, osteoarthritis, mechanical and compressive etiologies, and chronic back pain. There is no evidence of significant pain relief or increased function from the opioids used to date. The prescribing physician does not specifically address function with respect to prescribing opioids, and does not address the other recommendations in the MTUS. The MTUS states that a therapeutic trial of opioids should not be employed until the patient has failed a trial of non-opioid analgesics. There is no evidence that the treating physician has utilized a treatment plan NOT using opioids, and that the patient has failed a trial of non-opioid analgesics. Ongoing management should reflect four domains of monitoring, including analgesia, activities of daily living, adverse side effects, and aberrant drug-taking behaviors. The documentation does not reflect improvement in pain. Change in activities of daily living, discussion of adverse side effects, and screening for aberrant drug-taking behaviors were not documented. The physician documented that the injured worker did not abuse or share medications, but there was no detailed discussion of screening for aberrant behavior. No urine drug screens were submitted. It was noted that the medications allowed the injured worker to perform some activities but no there was no discussion of improvement in these activities of daily living. The MTUS recommends urine drug screens for patients with poor pain control and to help manage patients at risk of abuse. There is no record of a urine drug screen program performed according to quality criteria in the MTUS and other guidelines. As currently prescribed, hydrocodone/acetaminophen does not meet the criteria for long term opioids as elaborated in the MTUS and is therefore not medically necessary.

Morphine Sulfate ER 20mg #120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 89.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines opioids Page(s): 74-96.

Decision rationale: The injured worker has been prescribed morphine (avinza) and hydrocodone for at least 11 months and possibly as long as 5 years. There is no evidence that the treating physician is prescribing opioids according to the MTUS, which recommends prescribing according to function, with specific functional goals, return to work, random drug testing, and opioid contract. There should be a prior failure of non-opioid therapy. None of these aspects of prescribing are in evidence. Per the MTUS, opioids are minimally indicated, if at all, for chronic non-specific pain, osteoarthritis, mechanical and compressive etiologies, and chronic back pain. There is no evidence of significant pain relief or increased function from the opioids used to date. The prescribing physician does not specifically address function with respect to prescribing opioids, and does not address the other recommendations in the MTUS. The MTUS states that a therapeutic trial of opioids should not be employed until the patient has failed a trial of non-opioid analgesics. There is no evidence that the treating physician has utilized a treatment plan NOT using opioids, and that the patient has failed a trial of non-opioid analgesics. Ongoing management should reflect four domains of monitoring, including analgesia, activities of daily living, adverse side effects, and aberrant drug-taking behaviors. The documentation does not reflect improvement in pain. Change in activities of daily living, discussion of adverse side effects, and screening for aberrant drug-taking behaviors were not documented. The physician documented that the injured worker did not abuse or share medications, but there was no detailed discussion of screening for aberrant behavior. No urine drug screens were submitted. It was noted that the medications allowed the injured worker to perform some activities but there was no discussion of improvement in these activities of daily living. The MTUS recommends urine drug screens for patients with poor pain control and to help manage patients at risk of abuse. There is no record of a urine drug screen program performed according to quality criteria in the MTUS and other guidelines. As currently prescribed, morphine sulfate ER does not meet the criteria for long term opioids as elaborated in the MTUS and is therefore not medically necessary.

Setraline 50mg #120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 13-16.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 15 Stress Related Conditions Page(s): 401-402, Chronic Pain Treatment Guidelines antidepressants p. 14-16SSRIs p. 107 Page(s): 14-16, 107. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) mental illness and stress chapter: antidepressants for treatment of major depressive disorder.

Decision rationale: The MTUS states that antidepressants are recommended as a first line option for neuropathic pain and as a possibility for non-neuropathic pain. Assessment of

treatment efficacy should include not only pain outcomes, but also an evaluation of function, changes in use of other analgesic medication, sleep quality and duration, and psychological assessment. Selective serotonin reuptake inhibitors (SSRIs) are controversial based on clinical trials. It has been suggested that the main role of SSRIs may be in addressing psychological symptoms associated with chronic pain. The documentation notes that sertraline eases stress caused by chronic pain and improves interpersonal activities for this injured worker. A diagnosis of depression in remission was noted, but there was no detailed discussion of symptoms of depression and minimal psychiatric examination findings discussed. There was no documentation of functional improvement as a result of use of this medication; work status was not discussed other than a notation from 2009 that the injured worker was medically retired, there was no reduction in medication or decrease in frequency of office visits. The ACOEM notes that brief courses of antidepressants may be helpful to alleviate symptoms of depression, but that given the complexity of available agents, referral for medication evaluation is advised. The ODG states that antidepressants offer significant benefit in the treatment of the severest depressive symptoms, but may have little or no therapeutic benefit over and above placebo in patients with mild to moderate depression. Severity of depression was not discussed other than some notations that the injured worker had depression in remission. Sertraline has been prescribed for at least 11 months and possibly as long as 5 years. There was no documentation of psychiatric referral or evaluation. Due to lack of sufficient psychiatric evaluation, and lack of functional improvement, the request for sertraline is not medically necessary.

Tizanidine 4mg #480: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 66.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines muscle relaxants Page(s): 63-66.

Decision rationale: The MTUS for chronic pain does not recommend muscle relaxants for chronic pain. Non-sedating muscle relaxants are an option for short-term exacerbations of chronic low back pain. The muscle relaxant prescribed in this case is sedating. The injured worker has chronic pain with no evidence of prescribing for flare-ups. The quantity prescribed implies long term use, not for a short period of use for acute pain. Tizanidine has been prescribed for 11 months and possibly for as long as 5 years. No reports show any specific and significant improvement in pain or function as a result of prescribing muscle relaxants. It was noted that tizanidine eased back muscle spasm and allowed more mobility and ability to perform household functions, but specific improvement in activities of daily living were not discussed. Tizanidine (Zanaflex) is FDA approved for management of spasticity and unlabeled for use for low back pain. Side effects include somnolence, dizziness, dry mouth, hypotension, weakness, and hepatotoxicity. Liver function tests should be monitored. It should be used with caution in renal impairment and avoided in hepatic impairment. There was no documentation of laboratory monitoring. Due to prolonged length of use not in accordance with the guidelines, lack of functional improvement, and lack of monitoring for toxicity, the request for tizanidine is not medically necessary.