

<b>Case Number:</b>	CM15-0100708		
<b>Date Assigned:</b>	06/03/2015	<b>Date of Injury:</b>	08/03/2011
<b>Decision Date:</b>	07/08/2015	<b>UR Denial Date:</b>	05/21/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/26/2015

### 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: Arizona, Michigan

Certification(s)/Specialty: Preventive Medicine, Occupational 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 injured worker is a 53 year old male, who sustained an industrial injury on August 3, 2011. He reported injuring his shoulder while trying to do something with the wheel lock on a semitrailer. The injured worker was diagnosed as having right shoulder pain, chronic pain syndrome, right elbow pain, right wrist pain, reflux sympathetic dystrophy of the upper extremity, allodynia of the right upper extremity, left C6 radiculitis, and carpal tunnel syndrome. Treatment to date has included MRIs, x-rays, right shoulder surgery, electromyography (EMG)/nerve conduction velocity (NCV), a bone scan, CT scan, epidural steroid injection (ESI), physical therapy, trigger point injections, trigger finger release, psychiatric follow-up, and medication. Currently, the injured worker complains of burning, stabbing, and aching in his neck on the right, and right shoulder and right upper extremity pain. The Treating Physician's report dated April 16, 2015, noted the injured worker continued to follow up with his psychologist and psychiatrist, with prescriptions of Latuda and Cymbalta helping with a positive change in attitude. The injured worker's current medications were noted to be helpful and well tolerated, including Lidoderm patches, Nucynta ER, Nucynta IR, Naproxen, Omeprazole, Gabapentin, Lunesta, and Flexeril. The injured worker reported his pain as 10/10 on the visual analog scale (VAS) without medications and a 5-8/10 with medications, unchanged since previous appointment. Physical examination was noted to show tenderness to palpation of the right shoulder and right upper extremity diffusely, with limited range of motion (ROM) of the right shoulder, elbow, and wrist. Sensation to light touch caused pain over the entire right upper extremity. The treatment plan was noted to include a urine drug screen (UDS), consistent with what was being prescribed, and prescriptions for Nucynta, Prilosec, and Anaprox, dispensed Naproxen, and Omeprazole, with continued medication management of all current medications.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Tramadol ER 150mg #60:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Tramadol (Ultram) Page(s): 74-96, 113.

**Decision rationale:** The MTUS states that tramadol is a centrally acting synthetic opioid analgesic and it is not recommended as a first-line oral analgesic. Opioids are recommended for chronic pain, especially neuropathic pain that has not responded to first line recommendations like antidepressants and anticonvulsants. Long term users should be reassessed per specific guideline recommendations and the dose should not be lowered if it is working. Per the MTUS, Tramadol is indicated for moderate to severe pain. A review of the injured workers medical records that are available to me reveal subjective and objective findings of moderate pain, with documented benefit from tramadol use in the past, however this medication must have been discontinued for some reason which is not clear in the medical records and without this information restarting tramadol is not medically necessary.

**Percocet 10/325mg #90:** Upheld

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

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

**Decision rationale:** Per the MTUS, opioids should be discontinued if there is no overall improvement in function, unless there are extenuating circumstances, Opioids should be continued if the patient has returned to work or has improved functioning and pain. Ongoing management actions should include prescriptions from a single practitioner, taken as directed and all prescriptions from a single pharmacy. The lowest possible dose should be prescribed to improve pain and function. Documentation should follow the 4 A's of analgesia, activities of daily living, adverse side effects, and aberrant drug taking behaviors. Long term users of opioids should be regularly reassessed. In the maintenance phase the dose should not be lowered if it is working. Also, patients who receive opioid therapy may sometimes develop unexpected changes in their response to opioids, which includes development of abnormal pain, change in pain pattern, persistence of pain at higher levels than expected when this happens opioids can actually increase rather than decrease sensitivity to noxious stimuli. It is important to note that a decrease in opioid efficacy should not always be treated by increasing the dose or adding other opioids, but may actually require weaning. A review of the injured workers medical records reveal a request by the injured worker to restart Percocet due to denials of his Nucynta, unfortunately the rationale for why this medication was discontinued in the past is not given and while there is documentation of pain and functional improvement with the use of opioids, it is not clear if this also happened with Percocet and without this information the request for Percocet is not medically necessary.

**Cyclobenzaprine 10mg #60 with 3 refills: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Cyclobenzaprine (Flexeril) Page(s): 41-42.

**Decision rationale:** Per the MTUS, Cyclobenzaprine is recommended as an option in the treatment of chronic pain using a short course of therapy. It is more effective than placebo in the management of back pain; the effect is modest and comes at the price of greater adverse effects. The effect is greatest in the first 4 days of treatment suggesting that shorter courses may be better. Treatment should be brief. Treatment is not recommended for longer than 2-3 weeks. A review of the injured workers medical records that are available to me did not reveal objective documentation of ongoing muscle spasm, neither were there any extenuating physical findings that would warrant deviating from the guidelines, the request for Cyclobenzaprine 10mg #60 with 3 refills suggests chronic use as opposed to short term use and is not supported by the guidelines, therefore the request for Cyclobenzaprine 10mg #60 with 3 refills is not medically necessary.

**Lunesta 2mg #30 with 3 refills: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Mental Illness & Stress Chapter: Insomnia treatment (2015).

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Mental Illness and Stress / Eszopicolone (Lunesta).

**Decision rationale:** The MTUS did not specifically address the use of Lunesta, therefore other guidelines were consulted. Per the ODG, " Not recommended for long-term use, but recommended for short-term use. See Insomnia treatment. See also the Pain Chapter. Recommend limiting use of hypnotics to three weeks maximum in the first two months of injury only, and discourage use in the chronic phase. While sleeping pills, so-called minor tranquilizers, and anti-anxiety agents are commonly prescribed in chronic pain, pain specialists rarely, if ever, recommend them for long-term use. They can be habit-forming, and they may impair function and memory more than opioid pain relievers. There is also concern that they may increase pain and depression over the long-term. In this study, Eszopiclone (Lunesta) had a Hazard ratio for death of 30.62 (C.I., 12.90 to 72.72), compared to Zolpidem at 4.82 (4.06 to 5.74). In general, receiving hypnotic prescriptions was associated with greater than a threefold increased hazard of death even when prescribed less than 18 pills/year. (Kripke, 2012) The FDA has lowered the recommended starting dose of eszopiclone (Lunesta) from 2 mg to 1 mg for both men and women. Previously recommended doses can cause impairment to driving skills, memory, and coordination as long as 11 hours after the drug is taken. Despite these long-lasting effects, patients were often unaware they were impaired." A review of the injured workers medical records that are available to me do not reveal documentation of improvement in sleep latency, quality or quantity with the use of Lunesta and without this information continued use is not medically necessary.

**Neurontin 800mg #90 with 3 refills:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines anti-epilepsy drugs.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Antiepilepsy drugs (AED's), Medications for chronic pain Page(s): 16-22, 60-61.

**Decision rationale:** Per the MTUS, anti-epilepsy drugs are recommended for neuropathic pain. Gabapentin is considered first line treatment for neuropathic pain. The choice of specific agents reviewed below will depend on the balance between effectiveness and adverse reactions. A "good" response to the use of AEDs has been defined as a 50% reduction in pain and a "moderate" response as a 30% reduction. It has been reported that a 30% reduction in pain is clinically important to patients and a lack of response of this magnitude may be the "trigger" for the following: (1) a switch to a different first-line agent (TCA, SNRI or AED are considered first-line treatment); or (2) combination therapy if treatment with a single drug agent fails.(Eisenberg, 2007) (Jensen, 2006) After initiation of treatment there should be documentation of pain relief and improvement in function as well as documentation of side effects incurred with use. The continued use of AEDs depends on improved outcomes versus tolerability of adverse effects. A review of the injured workers medical records reveal documentation of improvement in pain and function with the use of his current medications however it is unclear how much of this is attributable specifically to Gabapentin, the guidelines recommend medications be introduced one at a time with documentation of improved pain and function, without this information continued use is not medically necessary.

**Lidoderm patches 5% #90 with 3 refills:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113.

**Decision rationale:** Per the MTUS, topical analgesics are recommended as an option, they are largely experimental in use with few randomized controlled trials to determine efficacy or safety. They are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Many agents are compounded as monotherapy or in combination for pain control, any compounded product that contains at least one drug or drug class that is not recommended is not recommended. Lidocaine is approved for use in the form of a dermal patch. Gels, creams or lotions are not indicated for neuropathic pain and lidocaine is not recommended for non-neuropathic pain. A review of the injured workers medical records reveal documentation of improvement in pain and function with the use of his current medications however it is unclear how much of this is attributable specifically to Lidoderm, the guidelines recommend medications be introduced one at a time with documentation of improved pain and function, without this information continued use is not medically necessary.

**Naproxen Sodium 550mg #60:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines non-steroidal anti-inflammatory drugs.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAID's, Medications for chronic pain Page(s): 67-68, 61.

**Decision rationale:** Per the MTUS, NSAIDs are recommended at the lowest dose for the shortest period in patients with moderate to severe pain. Acetaminophen may be considered for initial therapy for patients with mild to moderate pain, and in particular, for those with gastrointestinal, cardiovascular or renovascular risk factors. NSAIDs appear to be superior to acetaminophen, particularly for patients with moderate to severe pain. There is no evidence to recommend one drug in this class over another based on efficacy. In particular, there appears to be no difference between traditional NSAIDs and COX-2 NSAIDs in terms of pain relief. The main concern of selection is based on adverse effects. COX-2 NSAIDs have fewer GI side effects at the risk of increased cardiovascular side effects, although the FDA has concluded that long-term clinical trials are best interpreted to suggest that cardiovascular risk occurs with all NSAIDs and is a class effect (with naproxen (being the safest drug). There is no evidence of long-term effectiveness for pain or function. A review of the injured workers medical records reveal documentation of improvement in pain and function with the use of his current medications however it is unclear how much of this is attributable specifically to Naproxen, the guidelines recommend medications be introduced one at a time with documentation of improved pain and function, without this information continued use is not medically necessary.