

Case Number:	CM15-0109565		
Date Assigned:	06/18/2015	Date of Injury:	06/13/2014
Decision Date:	07/22/2015	UR Denial Date:	06/01/2015
Priority:	Standard	Application Received:	06/08/2015

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: 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:

This 44 year old woman sustained an industrial injury on 6/13/2014. Evaluations include lumbar spine MRI dated 8/2/2014 which showed multilevel degenerative disc disease with disc bulges. Diagnoses include lumbar spondylosis, lumbosacral neuritis, and lumbago. Treatment has included oral medications and physical therapy. Ibuprofen and tramadol were prescribed in February of 2015. Physician notes on an orthopedic PR-2 dated 5/6/2015 show complaints of low back pain rated 10/10. Current medications include cozaar, duloxetine, hydrochlorothiazide, ibuprofen, klor-con, norvasc, ranitidine, tramadol, xanax, etodolac, methocarbamol, and tylenol. Examination showed tenderness to palpation in the back at the lumbar spine both midline and paraspinous, normal motor function testing, and normal sensation. A signed opioid agreement was noted. Recommendations include lumbar spine MRI, Gabapentin, Tramadol, Etodolac, Duloxetine, and follow up in four weeks. At a visit with the primary treating physician on 5/7/15, the injured worker reported low back pain radiating to both legs with weakness and numbness. Work status was noted as modified duty. Anaprox, fexmid, and ultram were prescribed, and a urine drug screen was performed. On 6/1/15, Utilization Review non-certified requests for the items currently under Independent Medical Review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retrospective request for Anaprox-DS Naproxen Sodium 550mg #90 for the service date of 05/07/2015: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-inflammatory medications.

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

Decision rationale: This injured worker has chronic back pain. Non-steroidal anti-inflammatory agents have been prescribed for at least three months. Per the MTUS, non-steroidal 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. This injured worker reported a history of hypertension on a questionnaire submitted to the physician. NSAIDS 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. Package inserts for NSAIDS recommend periodic monitoring of a CBC and chemistry profile (including liver and renal function tests). There is no evidence that the prescribing physician is adequately monitoring for toxicity as recommended by the FDA and MTUS. The submitted records indicate that the treating orthopedist has prescribed etodolac, and the medication list in the orthopedic progress note from 5/6/15 included both ibuprofen and etodolac (both NSAIDS). The next day, on 5/7/15, the primary treating physician prescribed anaprox DS, another NSAID. The concurrent use of three different NSAIDS is duplicative and potentially toxic. There was no report of improvement in pain or function as a result of use of NSAIDS. There was no documentation of decrease in work restrictions or improvement in activities of daily living. Due to chronic use, which is not in accordance with the guidelines, lack of functional improvement, and simultaneous prescription of several nonsteroidals with potential for toxicity, the request for Anaprox DS is not medically necessary.

Retrospective request for Fexmid Cyclobenzaprine 7.5mg #60 for the service date of 05/07/2015: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants (for pain).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines cyclobenzaprine, muscle relaxants Page(s): 41-42, 63-66.

Decision rationale: This injured worker has chronic back pain. 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. No reports show any specific and significant improvement in pain or function as a result of prescribing muscle relaxants. Per the MTUS chronic pain medical treatment guidelines, cyclobenzaprine (Flexeril, Fexmid, Amrix, Trabadol) is a skeletal muscle relaxant and a central nervous system depressant. It is recommended as an option for a short course of therapy, with greatest effect in the first four days of treatment. Guidelines state that treatment should be brief. Cyclobenzaprine is not recommended to be used for longer than 2-3 weeks. Limited, mixed evidence does not allow for a recommendation for chronic use. The addition of cyclobenzaprine to other agents is not recommended. This injured worker has been prescribed multiple additional agents. The submitted records show methocarbamol, another muscle relaxant in the medication list from the orthopedist at the visit on 5/6/15. Fexmid was prescribed on 5/7/15 by the primary treating physician, without discussion of discontinuation of methocarbamol, which is duplicative and potentially toxic. Due to quantity prescribed in excess of the guideline recommendations for a short course of treatment, and potential for toxicity with use of two muscle relaxants simultaneously, the request for Fexmid is not medically necessary.

Retrospective request for Ultram Tramadol HCL ER 150mg #60 for the service date of 05/07/2015: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids for Chronic Pain, Tramadol (Ultram).

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

Decision rationale: This injured worker has chronic back pain. Tramadol has been prescribed for at least three months. Tramadol (Ultram) is a centrally acting synthetic opioid analgesic, which is not recommended as a first line oral analgesic. Multiple side effects have been reported including increased risk of seizure especially in patients taking selective serotonin reuptake inhibitors (SSRIs), tricyclic antidepressants (TCAs) and other opioids. It may also produce life-threatening serotonin syndrome. This injured worker has also been prescribed duloxetine, another serotonergic medication, which increases the potential for serotonin syndrome. There is insufficient 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. No functional goals were discussed. No prior urine drug screens were submitted. 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. There was no discussion of decrease in work restrictions or improvement in activities of daily living. 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 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. The records show that this injured worker is receiving opioids from more than one physician in the very recent past, with Tramadol prescribed by the orthopedist on 5/6/15 and by the primary treating physician on 5/7/15. The MTUS recommends that patients receive their medication from one physician and one pharmacy only. There is no evidence that either of the prescribing physicians was aware that this was occurring. As currently prescribed, Ultram does not meet the criteria for long term opioids as elaborated in the MTUS and is therefore not medically necessary.

Retrospective request for a drug screen full panel drug screen for the service date of 05/07/2015: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines chronic pain medical treatment guidelines: drug testing p. 43, opioids p. 77- 78, p. 89, p. 94. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) chronic pain chapter: urine drug testing, opioids, screening tests for risk of addiction and misuse.

Decision rationale: Per MTUS chronic pain medical treatment guidelines, urine drug screens are recommended as an option to assess for the use or the presence of illegal drugs, in accordance with a treatment plan for use of opioid medication, and as a part of a pain treatment agreement for opioids. Per the ODG, urine drug testing is recommended as a tool to monitor compliance with prescribed substances, identify use of undisclosed substances, and uncover diversion of prescribed substances. Urine drug testing is recommended at the onset of treatment when chronic opioid management is considered, if the patient is considered to be at risk on addiction screening, or if aberrant behavior or misuse is suspected or detected. Ongoing monitoring is recommended if a patient has evidence of high risk of addiction and with certain clinical circumstances. Frequency of urine drug testing should be based on risk stratification. Patients with low risk of addiction/aberrant behavior should be tested within six months of initiation of therapy and on a yearly basis thereafter. Patients at moderate risk for addiction/aberrant behavior should be tested 2-3 times per year. Patients at high risk of adverse outcomes may require testing as often as once a month. Random collection is recommended. Results of testing should be documented and addressed. In this case, there was no documentation of risk stratification for aberrant behavior, which is necessary to determine the frequency of testing. Although the documentation indicates the use of opioids for at least several months, no prior urine drug screens were submitted or discussed; the date of any prior urine drug testing would be necessary to determine when such testing would again be indicated. In addition, the associated opioid, Tramadol, has been determined to be not medically necessary. As the documentation was insufficient for determination of necessary frequency of testing, and as the associated opioid was determined to be not medically necessary, the request for full panel drug screen is not medically necessary.