

<b>Case Number:</b>	CM15-0137821		
<b>Date Assigned:</b>	07/27/2015	<b>Date of Injury:</b>	02/19/2001
<b>Decision Date:</b>	09/25/2015	<b>UR Denial Date:</b>	06/15/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/16/2015

### 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: California

Certification(s)/Specialty: Physical Medicine & Rehabilitation

### 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 61 year old female who sustained an industrial injury on 02/19/2001. According to a progress report dated 05/21/2015, the injured worker had an improvement of her headaches. Topamax was controlling them. Neck pain had improved. She changed pillows which eventually seemed to help. Over all she did well back on her medication regimen with the higher Cymbalta dose. Pain and range of motion in the hand and shoulder were better. She often dropped things and had trouble picking things up with the right hand. She had started to have difficulty with the right thumb getting stuck in the adducted position often, and prying it into normal position was painful. She was seen by another provider who thought there was nerve damage and no arthritis and recommended electrodiagnostic studies. She was currently happy with the current treatment with little side effects from the medications. Trazodone was better at ½ tabs but occasionally she needed 1 full tab to sleep. Neck and arm symptoms were similar to previous visits. Physical examination demonstrated tenderness and stiffness on the right with cervical palpation. There was discomfort, limited rotation of the right side, limited bend on the right and limited extension with cervical range of motion. The right wrist and thumb was tender. Right shoulder flexion, shoulder abduction and wrist extension was limited. There was a support wrap on the right wrist. Painful and limited range of motion was noted at the right 1st proximal interphalangeal joint and metacarpophalangeal joints. Motor was limited at the right wrist, elbow and shoulder by pain 4/5. Sensation was intact bilaterally to touch. Diagnoses included repetitive stress syndrome right upper extremity, status post right carpal tunnel release, fibromyalgia and right thumb pain with trigger thumb. The treatment plan included electrodiagnostic studies of the

right upper extremity and a return follow up appointment in 1 month. Medications refilled included Norco, Cymbalta, Baclofen and Topamax. Trazodone was not due. Employment status was noted as disabled. Currently under review is the request for Norco 10/325 mg #240 and Baclofen, unspecified dosage and quantity.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**Norco 10/325mg #240:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Hydrocodone/Acetaminophen, Opioids.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Medications for chronic pain Criteria for use of Opioids Page(s): 60, 61, 76-78, 88, 89.

**Decision rationale:** Based on the 5/21/15 progress report provided by the treating physician, this patient presents with improved headaches, improved neck pain, improved range of motion in hand and shoulder, but increased difficulty with right thumb getting stuck in adducted position. The treater has asked for Norco 10/325mg #240 on but the requesting progress report is not included in the provided documentation. The request for authorization dated 6/8/15 gave diagnosis as pain in hand/joint/thumb. The patient states that Trazodone is better at 1/2 tab, but occasionally needs full tab to sleep per 5/21/15 report. The patient is currently taking Topamax, Baclofen, Norco, Trazodone and Cymbalta per 5/21/15 report. The patient has been taking Norco and Baclofen as early as 4/24/12 report. The patient complains of full body pain due to fibromyalgia per 1/27/15 report. The patient has frequent numbness diffusely in the right hand, and occasional numbness in thumb and middle finger of left hand per 3/4/15 report. The patient's work status is disabled per 1/27/15 report. MTUS Guidelines pages 88 and 89 states, "Pain should be assessed at each visit, and functioning should be measured at 6-month intervals using a numerical scale or validated instrument." MTUS page 78 also requires documentation of the 4As (analgesia, ADLs, adverse side effects, and adverse behavior), as well as "pain assessment" or outcome measures that include current pain, average pain, least pain, intensity of pain after taking the opioid, time it takes for medication to work and duration of pain relief. MTUS page 77 states, "function should include social, physical, psychological, daily and work activities, and should be performed using a validated instrument or numerical rating scale." MTUS p90 states, "Hydrocodone has a recommended maximum dose of 60mg/24hrs". The treater does not discuss this request in the reports provided. Patient has been taking Norco since 4/24/12 and in reports dated 8/6/13, 5/20/14, and 5/21/15. MTUS requires appropriate discussion of all the 4A's; however, in addressing the 4A's, the treater does not discuss how this medication significantly improves patient's activities of daily living. No validated instrument is used to show analgesia. There is no UDS, no CURES and no opioid contract provided. Given the lack of documentation as required by MTUS, the request does not meet the specifications given by the guidelines. In addition, Hydrocodone is recommended for a maximum dosage of 60mg/24 hours. Therefore, the request is not medically necessary.

**Baclofen, unspecified dosage and quantity:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Baclofen (Lioresal).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants for Pain Page(s): 63.

**Decision rationale:** Based on the 5/21/15 progress report provided by the treating physician, this patient presents with improved headaches, improved neck pain, improved range of motion in hand and shoulder, but increased difficulty with right thumb getting stuck in adducted position. The treater has asked for Baclofen, unspecified dosage and quantity but the requesting progress report is not included in the provided documentation. The request for authorization dated 6/8/15 gave diagnosis as pain in hand/joint/thumb. The patient states that Trazodone is better at 1/2 tab, but occasionally needs full tab to sleep per 5/21/15 report. The patient is currently taking Topamax, Baclofen, Norco, Trazodone and Cymbalta per 5/21/15 report. The patient has been taking Norco and Baclofen as early as 4/24/12 report. The patient complains of full body pain due to fibromyalgia per 1/27/15 report. The patient has frequent numbness diffusely in the right hand, and occasional numbness in thumb and middle finger of left hand per 3/4/15 report. The patient's work status is disabled per 1/27/15 report. MTUS, Muscle Relaxants for Pain, pg. 63: Recommend non-sedating muscle relaxants with caution as a second-line option for short-term treatment of acute exacerbations in patients with chronic LBP. (Chou, 2007) (Mens, 2005) (Van Tulder, 1998) (Van Tulder, 2003) (Van Tulder, 2006) (Schnitzer, 2004) (See, 2008) Muscle relaxants may be effective in reducing pain and muscle tension, and increasing mobility. However, in most LBP cases, they show no benefit beyond NSAIDs in pain and overall improvement. Also there is no additional benefit shown in combination with NSAIDs. Efficacy appears to diminish over time, and prolonged use of some medications in this class may lead to dependence. (Homik, 2004) Sedation is the most commonly reported adverse effect of muscle relaxant medications. These drugs should be used with caution in patients driving motor vehicles or operating heavy machinery. Drugs with the most limited published evidence in terms of clinical effectiveness include chlorzoxazone, methocarbamol, dantrolene and baclofen. (Chou, 2004) According to a recent review in American Family Physician, skeletal muscle relaxants are the most widely prescribed drug class for musculoskeletal conditions (18.5% of prescriptions), and the most commonly prescribed antispasmodic agents are carisoprodol, cyclobenzaprine, metaxalone, and methocarbamol, but despite their popularity, skeletal muscle relaxants should not be the primary drug class of choice for musculoskeletal conditions. (See2, 2008) Classifications: Muscle relaxants are a broad range of medications that are generally divided into antispasmodics, anti-spasticity drugs, and drugs with both actions. (See, 2008) (Van Tulder, 2006). Patient has taken Baclofen as early as 4/24/12 and also in reports dated 1/14/14 and 4/8/14. In regard to the continuation of Baclofen, the requesting provider has exceeded guideline recommendations. MTUS guidelines do not support the use of muscle relaxants such as Baclofen long term. As there is no specification of dosage or quantity, it is not clear if treater intended this medication to be used for the short term. Therefore, the request is not medically necessary.