

Case Number:	CM15-0197458		
Date Assigned:	10/12/2015	Date of Injury:	05/03/1995
Decision Date:	12/30/2015	UR Denial Date:	09/24/2015
Priority:	Standard	Application Received:	10/07/2015

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: Florida, New York,
 Pennsylvania Certification(s)/Specialty: Family
 Practice

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 69 year old female who sustained an industrial injury on 05-03-1995. According to a progress report dated 09-17-2015, the injured worker was seen for neck pain. Pain with medications was rated 4 on a scale of 1-10. Pain without medications was rated 9. Quality of sleep was fair. Activity level had remained the same. Medications were working "well". There were no reported side effects. Current medications included Imitrex 6 mg daily as needed, Flexeril 10 mg three times a day as needed, MS Contin 30 mg ER one every bedtime, MS Contin 60 mg SA one twice daily, Percocet 10-325 mg three times a day as needed, Norco 10-325 mg every 4-6 hours as needed for pain maximum 6 per day and Risperidone 0.5 mg daily. The provider noted that urine toxicology on 08-01-2013 was noted as consistent. CURES report on 08-01-2013 was noted as appropriate. Diagnoses include post lumbar laminectomy syndrome, spasm of muscle post cervical laminectomy syndrome and cervical spondylosis. The injured worker was able to sleep 7 hours per night and tolerated her activities of daily living including household chores. Without Norco, the injured worker had difficulty resting at night due to pain and had difficulty with simple chores such as grocery shopping and doing dishes. Tapering of Norco was attempted and resulted in a decrease in function. MS Contin for long acting pain control allowed her to keep pain "well controlled" so that she could continue functioning at her baseline and maintain activities of daily living such as household chores and walking her dog. Without MS Contin she would be inactive and dependent on others for help in her home. Flexeril decreased muscle spasms. She frequently experienced muscle spasms when increasing activity and at night while trying to sleep. Flexeril reduced muscle spasm by 90%. With medications, the injured worker was able to perform

household tasks including laundry, meal preparation and self-care approximately 30-45 minutes at a time. Writing and computer use was limited to 15-30 minutes a day. Grocery shopping was limited to 30-45 minutes at a time. Without medications, the injured worker was able to perform household tasks including laundry, meal preparation and self-care approximately 10 minutes at a time. Writing and computer use was limited to 10 minutes or less per hour. Grocery shopping was limited to 15 minutes or less at a time. Prescriptions were given for MS Contin 30 mg #30, MS Contin 60 mg #60, Norco 10-325 mg #90 and Flexeril 10 mg #90. Documentation shows long term use of MS Contin, Norco and Flexeril. Urine toxicology report performed on 05-18-2015 was noted as consistent. On 09-24- 2015, Utilization Review modified the request for MS Contin 30 mg #30, MS Contin 60 mg #60, Norco 10-325 mg #90 and non-certified the request for Flexeril 10 mg #90.

IMR ISSUES, DECISIONS AND RATIONALES

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

MS Contin 30mg #30: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Antidepressants for chronic pain, Antiepilepsy drugs (AEDs), Opioids, criteria for use, Opioids for chronic pain, Opioids for neuropathic pain, Opioids, cancer pain vs. nonmalignant pain, Opioids, dosing, Oral morphine, Venlafaxine (Effexor), Weaning of Medications.

Decision rationale: According to the Chronic Pain Medical Treatment Guidelines, Opioids are not recommended as a first-line therapy for neuropathic pain. Opioid analgesics and Tramadol have been suggested as a second-line treatment (alone or in combination with first-line drugs). Antidepressants such as the Tricyclics or SNRI's can be commended as a first line option for neuropathic pain, and as a possibility for non-neuropathic pain. Analgesia generally occurs within a few days to a week, whereas antidepressant effect takes longer to occur. 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. Anti-Epileptic medications have also been recommended for neuropathic pain. Most randomized controlled trials (RCTs) for the use of this class of medication for neuropathic pain have been directed at post-herpetic neuralgia and painful polyneuropathy. Gabapentin and Lyrica are examples of this class of agent. The provider struggles to continue to justify the use of large doses of Opioids, making reference to the MTUS and the Strategy for Maintenance. The argument is that 'you should not lower the dose of a medication if it is working'. The issue is to define 'working'. While the patient reports a consistent reduction in pain and improved tolerance to ADL's there are no objective measures for functional improvement and the member remains off work. In addition the total dose of Morphine and Morphine equivalent that is said to achieve this state gives a MED of 190 which is 60% over the recommended maximum MED of 120 (note the member continues to consume 180 Norco 10/325 per month). It is now suggested that rather than simply focusing on pain severity, improvements in a wide range of outcomes should

Be evaluated, including measures of functioning, appropriate medication use, and side effects. A recent epidemiologic study found that opioid treatment for chronic non-malignant pain did not seem to fulfill any of the key outcome goals including pain relief, improved quality of life, and/or improved functional capacity. The continued attempts to wean and discontinue this medication should be encouraged. Therefore, the request is not medically necessary.

MS Contin 60mg #60: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Antidepressants for chronic pain, Antiepilepsy drugs (AEDs), Opioids, criteria for use, Opioids for chronic pain, Opioids for neuropathic pain, Opioids, dosing, Oral morphine, Venlafaxine (Effexor), Weaning of Medications.

Decision rationale: According to the Chronic Pain Medical Treatment Guidelines, Opioids are not recommended as a first-line therapy for neuropathic pain. Opioid analgesics and Tramadol have been suggested as a second-line treatment (alone or in combination with first-line drugs). Antidepressants such as the Tricyclics or SNRI's can be commended as a first line option for neuropathic pain, and as a possibility for non-neuropathic pain. Analgesia generally occurs within a few days to a week, whereas antidepressant effect takes longer to occur. 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. Anti-Epileptic medications have also been recommended for neuropathic pain. Most randomized controlled trials (RCTs) for the use of this class of medication for neuropathic pain have been directed at post-herpetic neuralgia and painful polyneuropathy. Gabapentin and Lyrica are examples of this class of agent. The provider struggles to continue to justify the use of large doses of Opioids, making reference to the MTUS and the Strategy for Maintenance. The argument is that 'you should not lower the dose of a medication if it is working'. The issue is to define 'working'. While the patient reports a consistent reduction in pain and improved tolerance to ADL's there are no objective measures for functional improvement and the member remains off work. In addition the total dose of Morphine and Morphine equivalent that is said to achieve this state gives a MED of 190 which is 60% over the recommended maximum MED of 120 (note the member continues to consume 180 Norco 10/325 per month). It is now suggested that rather than simply focusing on pain severity, improvements in a wide range of outcomes should be evaluated, including measures of functioning, appropriate medication use, and side effects. A recent epidemiologic study found that opioid treatment for chronic non-malignant pain did not seem to fulfill any of the key outcome goals including pain relief, improved quality of life, and/or improved functional capacity. The continued attempts to wean and discontinue this medication should be encouraged. Therefore, the request is not medically necessary.

Norco 10/325mg #90: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids, criteria for use, Opioids for chronic pain, Opioids, dosing, Opioids, specific drug list.

Decision rationale: According to the Chronic Pain Medical Treatment Guidelines, Opioids are not recommended as a first-line therapy for neuropathic pain. Opioid analgesics and Tramadol have been suggested as a second-line treatment (alone or in combination with first-line drugs). Antidepressants such as the Tricyclics or SNRI's can be commended as a first line option for neuropathic pain, and as a possibility for non-neuropathic pain. Analgesia generally occurs within a few days to a week, whereas antidepressant effect takes longer to occur. 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. Anti-Epileptic medications have also been recommended for neuropathic pain. Most randomized controlled trials (RCTs) for the use of this class of medication for neuropathic pain have been directed at post-herpetic neuralgia and painful polyneuropathy. Gabapentin and Lyrica are examples of this class of agent. Opioids are considered a second-line treatment for several reasons: (1) head-to-head comparisons have found that opioids produce more side effects than TCAs and gabapentin; (2) long-term safety has not been systematically studied; (3) long term use may result in immunological and endocrine problems (including hypogonadism); (4) treatment may be associated with hyperalgesia; & (5) opioid use is associated with misuse/abuse. With long term use a meta-analysis found that opioids were more effective than placebo for reducing pain intensity but the benefit for physical function was small and was considered questionable for clinical relevance. Opioids can be recommended on a trial basis for short-term use after there has been evidence of failure of first-line medication options such as acetaminophen or NSAIDs when there is evidence of moderate to severe pain. They would be used in conjunction with these medications rather than as a replacement as in this case. The primary risk with continued use is that 36 to 56% of users have a lifetime risk for substance use disorders. Norco is considered a member of the short-acting family of opioids, usually used for breakthrough pain and as such faces a much higher risk of rebound pain and subsequent misuse. This member is not using the Norco for breakthrough but rather to augment the effect of her MS Contin bringing her total MED to 190mg which exceeds the maximum daily dose of 120 by 60%. This medication is not being used for its intended purpose nor is it being used in combination with a first line agent. Therefore the request is not medically necessary.

Flexeril 10mg #90: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Muscle relaxants (for pain).

Decision rationale: According to the Chronic Pain Medical Treatment Guidelines, the general class of agents used as muscle relaxants are generally recommended for short term use only and with caution due to side effects as second line agents for patients with exacerbations of back pain. There is no evidence that they will show a benefit beyond that of NSAID's or that

there is any additional benefit in combination with NSAID's. Efficacy appears to diminish with time and maximal benefit appears to decline after approximately 4 days. Sedation is the most common class effect and needs to be considered in those having to drive or operate heavy equipment. Reports indicated that the member remains totally disabled. While patient details muscle spasm none of the reported physical examinations report more than paraspinal tenderness. It is likely that the sedative side effects are what is offering the benefit from it's use. Other agents such as the ADD's would be more appropriate and efficacious. There is no mention of any objective evidence for functional improvement. Based on the short-term indications for use of this class of agent and failure to show objective evidence for improved function use of Flexeril cannot be supported. Therefore, the request is not medically necessary.