

<b>Case Number:</b>	CM15-0202529		
<b>Date Assigned:</b>	10/19/2015	<b>Date of Injury:</b>	09/04/2014
<b>Decision Date:</b>	12/22/2015	<b>UR Denial Date:</b>	10/06/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/14/2015

### 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: Washington, California

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:

This injured worker is a 68 year old male who sustained an industrial injury on 09-04-2014. The injured worker was diagnosed as having cervical strain with radiculitis, thoracic strain with myofascial pain, lumbar strain, cervical facet joint pain C5-C6 and C6-C7, cervical facet joint arthropathy, chronic neck pain and shoulder strain with impingement. comorbid conditions include diabetes. Treatments to date included physical therapy, chiropractic therapy, medication and cortisone injections. Cervical CT Scan on 9-10-2014 noted diffuse degenerative disc changes C3-T-3 associated with mild to moderate spinal stenosis. Cervical MRI on 12-1-2014 showed mild left-sided paracentral disc protrusion, marginal degenerative spurring and neuroforaminal narrowing at C4-5, C5-6, C6-7. Right shoulder x-ray on 7-1-2015 showed acromioclavicular osteoarthritis with an osteophyte impinging inferiorly. X-ray cervical spine on 07-01-2015 showed scattered multilevel degenerative disc disease, scattered joint facet arthritis and scoliosis. Upper extremity electromyographic studies was consistent with bilateral carpal tunnel syndrome and bilateral cubital tunnel syndrome. Urine drug screen was requested on 9-29-2015. On medical records dated 09-30-2015, the subjective complaints were noted as bilateral neck pain and bilateral shoulder pain. Pain was rated 6 out of 10. Current medications were listed as Norco (since at least 07-2015), Naproxen, Gabapentin, Tramadol ER and Flexeril. Objective findings were noted as tenderness of the cervical paraspinal muscles overlying the C5-C6 and C6-C7 facet joint and restricted cervical spine range of motion. There was full and painless range of motion in all limbs without instability. Motor and sensory exams of all limbs were normal. The Utilization Review (UR), dated 10-06-2015, indicated that a request for Norco 5mg #30,

Ultracet 37.5mg #60, MRI without contrast- cervical and MRI without contrast - lumbar was non- certified.

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

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

**Norco 5mg #30:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids, pain treatment agreement.

**MAXIMUS guideline:** Decision based on MTUS General Approaches 2004, Section(s): Initial Approaches to Treatment, and Chronic Pain Medical Treatment 2009, Section(s): Medications for chronic pain, Opioids (Classification), Opioids, California Controlled Substance Utilization Review and Evaluation System (CURES) [DWC], Opioids, criteria for use, Opioids for chronic pain, Opioids for neuropathic pain, Opioids for osteoarthritis, Opioids, cancer pain vs. nonmalignant pain, Opioids, dealing with misuse & addiction, Opioids, differentiation: dependence & addiction, Opioids, dosing, Opioids, indicators for addiction,.

**Decision rationale:** Hydrocodone-Acetaminophen (Norco) is a mixed medication made up of the short acting, opioid, hydrocodone, and acetaminophen, better known as Tylenol. It is recommended for moderate to moderately severe pain with usual dosing of 5-10 mg hydrocodone per 325 mg of acetaminophen taken as 1-2 tablets every 4-6 hours. Maximum dose according to the MTUS is limited to 4 gm of acetaminophen per day, which is usually 60-120 mg/day of hydrocodone. According to the MTUS opioid therapy for control of chronic neuropathic pain, while not considered first line therapy, is considered a viable alternative when other modalities have been tried and failed. When treating moderate to severe nociceptive pain, defined as non radicular pain caused by continual injury, the MTUS considers opioid therapy to be the standard of care. Success of this therapy is noted when there is significant improvement in pain or function. The risk with this therapy is the development of addiction, overdose and death. The pain guidelines in the MTUS directly address this issue and have outlined criteria for monitoring patients to allow for safe use of chronic opioid therapy. The patient has both nociceptive and radicular pain. Use of an opioid medication is indicated. The patient has been on opioid preparations for over one month. However, the provider has prescribed two short-acting opioid preparations (Norco and Ultracet). Only one short-acting opioid should be used. The medical records do show that the patient has failed pain control with first-line medication for radicular pain (gabapentin) and the provider is monitoring for aberrant drug use. However, there is no documentation of a patient contract for chronic opioid therapy nor a description of the effectiveness of the opioid medications or the presence or absence of side effects from opioid medications. This documentation is required for the safe use of chronic opioid medications. At this point in the care of this patient, continued use of Norco is not medically necessary. Medical necessity has not been established.

**Ultracet 37.5mg #60:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids, pain treatment agreement.

**MAXIMUS guideline:** Decision based on MTUS General Approaches 2004, Section(s): Initial Approaches to Treatment, and Chronic Pain Medical Treatment 2009, Section(s): Medications for chronic pain, Opioids (Classification), Opioids, California Controlled Substance Utilization Review and Evaluation System (CURES) [DWC], Opioids, criteria for use, Opioids for chronic pain, Opioids for neuropathic pain, Opioids for osteoarthritis, Opioids, cancer pain vs. nonmalignant pain, Opioids, dealing with misuse & addiction, Opioids, differentiation: dependence & addiction, Opioids, dosing, Opioids, indicators for addiction,.

**Decision rationale:** Tramadol/APAP (Ultracet, Ultracet ER) is a combination medication made up of the opioid, tramadol, and acetaminophen, better known as tylenol. Acetaminophen is considered the safest medication for use to treat chronic pain. However it should be used cautiously in combination preparations in order to prevent liver damage. Maximum dose according to the MTUS is limited to 4 gm of acetaminophen per day. Tramadol has mu-receptor opioid agonist activity and is used to treat moderate to severe pain. Tramadol/APAP ER is an extended release formulation of this medication. Appropriate dosing should not exceed 400 mg/day but only 300 mg/day for the ER formulation and it should be used with caution in any patient taking Selective Serotonin Reuptake Inhibitors (SSRI) as together they may cause a potentially fatal condition known as Serotonin Syndrome. There are no studies showing effective use of this medication for chronic pain that lasts greater than 3 months. However, the MTUS describes use of narcotics for control of chronic radicular and nociceptive pain. For nociceptive pain it is considered standard of care, for radicular pain it is recommended as a second-line medication after use or failure of first-line therapies such as antidepressants or antiepileptic drugs (AEDs). Success of this therapy is noted when there is significant improvement in pain or function. The risk with this therapy is the development of addiction, overdose and death. The MTUS has specific recommendations for following patients on chronic opioid therapy to prevent such morbidity and mortality from occurring. The patient has both nociceptive and radicular pain. Use of an opioid medication is recommended. The patient has been on opioid preparations for over one month. However, the provider has prescribed two short-acting opioid preparations (Norco and Ultracet). Only one short-acting opioid should be used. The medical records do show that the patient has failed pain control with first-line medication for radicular pain (gabapentin) and the provider is monitoring for aberrant drug use. However, the patient is taking an antidepressant medication that acts as a serotonin reuptake inhibitor. Additionally, there is no documentation of a patient contract for chronic opioid therapy nor a description of the effectiveness of the opioid medications or the presence or absence of side effects from opioid medications. This documentation is required for the safe use of chronic opioid medications. At this point in the care of this patient, continued use of Ultracet is not medically necessary. Medical necessity has not been established.

**MRI without contrast, cervical:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Neck and Upper Back Complaints 2004, Section(s): Special Studies.

**MAXIMUS guideline:** Decision based on MTUS Neck and Upper Back Complaints 2004, Section(s): Special Studies, Summary, Physical Examination. Decision based on Non-MTUS Citation American College of Radiology, Appropriateness Criteria for the Imaging of Chronic Neck Pain, Revised 2013.

**Decision rationale:** Magnetic Resonance Imaging (MRI) scans are medical imaging studies used in radiology to investigate the anatomy and physiology of the body in both healthy and diseased tissues. It is used to assess the body by clarifying the anatomy of the region tested. It can identify acute injuries (eg fractures, dislocations, infections), mechanical injuries (ligament or tendon strains), degenerative disorders (arthritis, tendinitis) or masses, tumors or cysts. It does not show function, only anatomy. When the history is non-specific for nerve compromise but conservative treatment has not been effective in improving the patient's symptoms, electromyography (EMG) and nerve conduction velocity (NCV) studies or Sensory Evoked Potentials (if the provider is wanting to exclude the diagnoses of spinal stenosis or spinal cord myelopathy) are recommended before having a MRI done. This patient had a cervical MRI performed less than one year ago. There has not been a significant change in symptomatology since that time nor has the cervical anatomy been modified by surgery. Electrodiagnostic testing did not reveal any evidence of a cervical radiculopathy. Considering all the above information, a cervical MRI is not medically necessary at this time. Medical necessity has not been established.

**MRI without contrast, lumbar:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Low Back Complaints 2004.

**MAXIMUS guideline:** Decision based on MTUS Low Back Complaints 2004, Section(s): Physical Examination, Special Studies, Summary. Decision based on Non-MTUS Citation American College of Radiology, Appropriateness Criteria for the Imaging of Lower Back Pain, Revised 2011.

**Decision rationale:** Magnetic Resonance Imaging (MRI) scans are medical imaging studies used in radiology to investigate the anatomy and physiology of the body in both healthy and diseased tissues. MRIs of the lower back are indicated in acute injuries with associated red flags, that is, signs and symptoms suggesting acutely compromised nerve tissue. In chronic situations the indications rely more on a history of failure to improve with conservative therapies, the need for clarification of anatomy before surgery, or to identify potentially serious problems such as tumors or nerve root compromise. When the history is non-specific for nerve compromise but conservative treatment has not been effective in improving the patient's symptoms, electromyography (EMG) and nerve conduction velocity (NCV) studies are recommended before having a MRI done. This patient does meet the criteria of prolonged or persistent symptoms despite conservative care but the symptoms are non-specific, the examination is negative for any radicular findings, there are no red flags and an EMG/NCV study has not been done. At this point in the care of this individual a MRI of the lower back is not medically necessary. Medical necessity has not been established.