

Case Number:	CM15-0240403		
Date Assigned:	12/17/2015	Date of Injury:	09/16/2003
Decision Date:	01/28/2016	UR Denial Date:	11/19/2015
Priority:	Standard	Application Received:	12/09/2015

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: Colorado

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 male with an industrial injury dated 09-16-2003. A review of the medical records indicates that the injured worker is undergoing treatment for status post lumbar spine injury, post laminectomy syndrome of lumbar, left shoulder adhesive capsulitis, cervical spine injury, status post cervical spinal fusion, right knee pain status post arthroscopy and sleep apnea secondary to the above. According to the progress note dated 10-19-2015, the injured worker reported severe low back, buttock and leg pain, status post lumbar and neck surgery, shoulder pain and knee pain. The injured worker reported that he doing well on his medications. He is more active. There was no aberrant behavior and no adverse side effects. Pain level was not documented in record. Medications include Norco (since at least April of 2015), Horizant (or generic Neurontin) and Flexeril (since at least September of 2015). Objective findings (07-13-2015, 08-17-2015, 09-21-2015, 10-19-2015) revealed antalgic gait, mild pain from the suboccipital region down to the trapezius and scapular area, decrease range of motion, mild tenderness in the posterior columns, right positive straight leg raises, and decreased sensation in his right lateral calf and lateral foot. Treatment has included diagnostic studies, prescribed medications, and periodic follow up visits. The utilization review dated 11-19-2015, non-certified the request for Norco 10-325mg #30 and Flexeril 10mg #60.

IMR ISSUES, DECISIONS AND RATIONALES

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

Norco 10/325mg #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids, criteria for use.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Functional improvement measures, Opioids, criteria for use, Opioids for chronic pain, Opioids, dealing with misuse & addiction, Opioids, long-term assessment.

Decision rationale: The Guidelines establish criteria for use of opioids, including long-term use (6 months or more). When managing patients using long-term opioids, the following should be addressed: Re-assess the diagnosis and review previous treatments and whether or not they were helpful. When re-assessing, pain levels and improvement in function should be documented. Pain levels should be documented every visit. Function should be evaluated every 6 months using a validated clinical assessment tool. ("The importance of an assessment is to have a measure that can be used repeatedly over the course of treatment to demonstrate improvement of function, or maintenance of function that would otherwise deteriorate.") Adverse effects, including hyperalgesia, should also be addressed each visit. Patient's motivation and attitudes about pain / work / interpersonal relationships can be examined to determine if patient requires psychological evaluation as well. Aberrant / addictive behavior should be addressed if present. Do not decrease dose if effective. Medication for breakthrough pain may be helpful in limiting overall medication. Follow up evaluations are recommended every 1-6 months. To summarize the above, the 4 A's of Drug Monitoring (analgesia, activities of daily living, adverse side effects, and aberrant drug-taking Behaviors) have been established. The monitoring of these outcomes over time should affect therapeutic decisions and provide a framework for documentation of the clinical use of these controlled drugs. (Passik, 2000) Several circumstances need to be considered when determining to discontinue opioids: 1) Verify patient has not had failure to improve because of inappropriate dosing or under-dosing of opioids. 2) Consider possible reasons for immediate discontinuation including diversion, prescription forgery, illicit drug use, suicide attempt, arrest related to opioids, and aggressive or threatening behavior in clinic. Weaning from the medication over 30 day period, under direct medical supervision, is recommended unless a reason for immediate discontinuation exists. If a medication contract is in place, some physicians will allow one infraction without immediate discontinuation, but the contract and clinic policy should be reviewed with patient and consequences of further violations made clear to patient. 3) Consider discontinuation if there has been no improvement in overall function, or a decrease in function. 4) Patient has evidence of unacceptable side effects. 5) Patient's pain has resolved. 6) Patient exhibits "serious non-adherence" or misuse. Per the Guidelines, Chelminski defines "serious substance misuse" as meeting any of the following criteria: (a) cocaine or amphetamines on urine toxicology screen (positive cannabinoid was not considered serious substance abuse); (b) procurement of opioids from more than one provider on a regular basis; (c) diversion of opioids; (d) urine toxicology screen negative for prescribed drugs on at least two occasions (an indicator of possible diversion); & (e) urine toxicology screen positive on at least two occasions for opioids not routinely prescribed. (Chelminski, 2005) 7) Patient requests discontinuing opioids. 8) Consider verifying that patient is in consultation with physician specializing in addiction to consider detoxification if patient continues to violate the

medication contract or shows other signs of abuse / addiction. 9) Document the basis for decision to discontinue opioids. Likewise, when making the decision to continue opioids long term, consider the following: Has patient returned to work: "Has patient had improved function and decreased pain with the opioids". For the patient of concern, he has no documented improvement in pain ratings over the last 9 months during which he has been taking Norco. (No pain ratings documented.) Patient has had no documented objective assessment / improvement in function with his current regimen which includes Norco. There are no documented discussions of the risks of long term opioid use. There is documented at each visit that patient has no side effects related to medications and no aberrant drug behaviors. There is evidence that patient has had monitoring for abuse of opioids, with 2 urine drug screens ordered in last 9 months. However, one of the urine drug screens has no results included for review, and the other urine drug screen 11/18/2015 showed positive for Soma. There is contradiction in the record as patient's pain management provider never indicates Soma is a medication patient takes (from that provider or otherwise), and patient's primary treating provider indicates pain management provider is prescribing Soma, as of 10/28/2015 (and before). There is no indication in the record that this discrepancy has been resolved, or the results of urine drug screens discussed with patient. Without evidence that the patient has improved with regard to function and pain on opioids, and without evidence that appropriate monitoring of opioid use is ongoing, the Norco refill request is not medically necessary.

Flexeril 10mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Cyclobenzaprine (Flexeril).

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

Decision rationale: Per the Guidelines, Cyclobenzaprine, and other antispasmodics are recommended for musculoskeletal pain associated with spasm, but only for a short course. It has been shown to help more than placebo with back pain and fibromyalgia, but has several side effects that limit its use. Furthermore, Cyclobenzaprine works best in the first 4 days of use, so short courses recommended, no more than 2-3 weeks. No quality consistent evidence exists to support chronic use of Cyclobenzaprine. Common side effects of Cyclobenzaprine include: anticholinergic effects (drowsiness, urinary retention and dry mouth). Sedative effects may limit use. Headache has been noted. This medication should be avoided in patients with arrhythmias, heart block, heart failure and recent myocardial infarction. Side effects limit use in the elderly. (See, 2008) (Toth, 2004) The records supplied indicate patient of concern has been taking Cyclobenzaprine greater than 2-3 weeks total, without documented improvement in pain ratings or objective improvement in function related to use of muscle relaxer. As there is no support, per the guidelines, for long term use, the request for Cyclobenzaprine and has patient has not had documented improvement with it, the request for Cyclobenzaprine is not medically necessary.