

Case Number:	CM14-0125802		
Date Assigned:	08/13/2014	Date of Injury:	07/06/1996
Decision Date:	10/14/2014	UR Denial Date:	07/22/2014
Priority:	Standard	Application Received:	08/08/2014

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. The expert reviewer is Board Certified in Occupational Medicine and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 claimant was injured on 07/06/96. Cyclobenzaprine, Baclofen, Trazodone, Gabapentin, Zolpidem, Morphine Sulfate, Hydrocodone/Acetaminophen, and Naproxen are under review. Diagnoses include carpal tunnel syndrome, cervical spondylosis, displacement of cervical disc and postlaminectomy syndrome, and shoulder sprain. On 01/23/14, he had predominantly axial cervical pain. His symptoms were worse on the right side. He was using medications but still had significant symptoms. His medications were helping somewhat and he indicated functional gain with his current treatment. Neck pain and headaches were worse. He was on multiple medications. He had no new neurologic deficits. He had aggravation of left axial symptoms and a diagnostic medial branch or facet joint block was recommended. He was to continue his medications as before per [REDACTED]. The claimant saw [REDACTED] on 02/03/14. He had multiple dates of injury from 07/06/96 through 10/25/00. He had a neurologic evaluation and had an extremely complex history of cervical and upper extremity complaints with multiple injuries and surgeries. He stated his neck pain seemed to have worsened. There was equally bothersome pain in both arms and he awakened with pain. He stated there was a screw loose in his fusion. He was taking Norco/Lortab, Gabapentin, Cyclobenzaprine/Baclofen/Flexeril and Morphine at times. He took Ambien to help him sleep and Trazodone was ineffective. He described pain in his legs and ankles. He had tenderness about the cervical region. His grip strength was symmetric. He had increased reflexes in the arms. He had normal sensory sensation and a slow gait. EMG and nerve conduction studies were normal. Diagnoses were multiply operated cervical spine with residual cervical and upper extremity pain/radiculitis and cervical degenerative disease. He had upper extremity overuse syndrome including operated carpal tunnel. There was no significant change. On 02/25/14, he related intolerable neck pain symptoms and wanted to address medication changes as discussed previously due to a flare-up of

his pain. He was not taking his daily prescribed dose of pain medications. There was no aberrant drug behavior. He appeared to be uncomfortable and had difficulty getting on the exam table. He continued multiple medications. He saw a nurse practitioner, [REDACTED]. He had x-rays of the cervical spine on 02/18/14. There was evidence of fusion with a plate and anterior subluxation of C4-5 with flexion compared to extension. There was also extensive laminectomy from C3-6. On 05/08/14, the reported neck pain and radiating pain to the upper extremities. He had trigger point injections in the past. He related manageable neck pain symptoms. He was to gradually reduce and wean off his medications. Over the past 2 weeks he was not using medications for breakthrough and there was no recent flare-up of his pain. He had tenderness to deep palpation. Overall his symptoms were stable. "Upper EMG" was recommended and they were awaiting approval for facet blocks.

IMR ISSUES, DECISIONS AND RATIONALES

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

Cyclobenzaprine 10mg #90: 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 Page(s): 74.

Decision rationale: The history and documentation do not objectively support the request for Cyclobenzaprine 10 mg #90. The MTUS Chronic Pain Medical Treatment guidelines state for Cyclobenzaprine (Flexeril), "Recommended as an option, using a short course of therapy. The effect is greatest in the first four days of treatment, suggesting that shorter courses may be better. (Browning, 2001). Treatment should be brief." Additionally, MTUS and ODG state "relief of pain with the use of medications is generally temporary and measures of the lasting benefit from this modality should include evaluating the effect of pain relief in relationship to improvements in function and increased activity. Before prescribing any medication for pain, the following should occur: (1) determine the aim of use of the medication; (2) determine the potential benefits and adverse effects; (3) determine the patient's preference. Only one medication to be given at a time, and interventions that are active and passive should remain unchanged at the time of the medication change. A trial should be given for each individual medication. Analgesic medication should show effects within 1 to 3 days, a record of pain and function with the medication should be recorded. (Mens 2005) Up-to-date for "Flexeril" also recommends "do not use longer than 2-3 weeks" and is for "short-term (2-3 weeks) use for muscle spasm associated with acute painful musculoskeletal conditions." The medical documentation provided does not establish the need for long-term/chronic usage of Cyclobenzaprine, which MTUS guidelines advise against. Additionally, the medical records provided do not provide objective findings of acute spasms or a diagnosis of acute spasm. In this case, the claimant's pattern of use of medications, including other first-line drugs such as acetaminophen and anti-inflammatories and the response to them, including relief of symptoms and documentation of functional improvement, have not been described. His pattern of use of this medication, the indications for use, and the response and

duration, are not stated in the records. As such, this request for Cyclobenzaprine hydrochloride 10 mg #90 is not medically necessary.

Baclofen 10mg #90: 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 Muscle relaxers, Baclofen Page(s): 97.

Decision rationale: The history and documentation do not objectively support the request for Baclofen 10 mg #90. The MTUS Chronic Pain Medical Treatment guidelines state "muscle relaxants (for pain) - 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." Before prescribing any medication for pain, the following should occur: (1) determine the aim of use of the medication; (2) determine the potential benefits and adverse effects; (3) determine the patient's preference. Only one medication to be given at a time, and interventions that are active and passive should remain unchanged at the time of the medication change. A trial should be given for each individual medication. Analgesic medication should show effects within 1 to 3 days, a record of pain and function with the medication should be recorded. (Mens 2005)" The medical documentation provided does not establish the need for long-term/chronic usage of Baclofen when the claimant is also being given Cyclobenzaprine. Additionally, the medical records provided do not provide objective findings of acute spasms or a diagnosis of acute spasm. In this case, the claimant's pattern of use of medications, including other first-line drugs such as acetaminophen and anti-inflammatories and the response to them, including relief of symptoms and documentation of functional improvement, have not been described. His pattern of use of this medication, the indications for use, and the response and duration, are not stated in the records. As such, this request for Baclofen 10 mg #90 is not medically necessary.

Trazadone HCL 50mg #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressants for chronic pain..

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG): Formulary - Trazodone for insomnia

Decision rationale: The history and documentation do not objectively support the request for Trazodone HCl 50 mg #30. The claimant appears to have tried it for sleep but he stated that it was not helpful and he was also given Zolpidem. The MTUS do not address its use and the ODG formulary states that Trazodone is "recommended as an option for insomnia, only for patients with potentially coexisting mild psychiatric symptoms such as depression or anxiety." There is no clear evidence of depression or anxiety for which this medication appears to have been provided to him. In addition, he stated it did not help. In addition, his sleep problems have not been clearly evaluated along with trials of basic sleep hygiene, prior to considering the use of pharmaceutical sleep aids. The medical necessity of the use of Trazodone 50 mg has not been clearly demonstrated.

Gabapentin 600mg #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-epilepsy drugs..

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Gabapentin Page(s): 83.

Decision rationale: The history and documentation do not objectively support the request for Gabapentin 600 mg #90. The MTUS state "Gabapentin is an anti-epilepsy drug (AEDs - also referred to as anti-convulsants), which has been shown to be effective for treatment of diabetic painful neuropathy and postherpetic neuralgia and has been considered as a first-line treatment for neuropathic pain." In this case, neither of these conditions has been documented and there is no evidence of other types of neuropathic pain such as radiculopathy (electrodiagnostic studies were normal). The indication for the use of this medication and the claimant's pattern of use and the benefit he gets from this medication, including functional improvement, have not been documented. There is no evidence that he has been involved in an ongoing exercise program to help maintain any benefit he receives from medication use. As a result, the medical necessity of Gabapentin 600mg #30 has not been clearly demonstrated.

Zolpidem 10mg #30: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines: Zolpidem (Ambien)

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) : Formulary - Zolpidem

Decision rationale: The history and documentation do not objectively support the request for Zolpidem 10 mg #30. The MTUS state sleep hygiene is important for patient with chronic pain and the ODG state "Zolpidem is a prescription short-acting nonbenzodiazepine hypnotic, which is approved for the short-term (usually two to six weeks) treatment of insomnia. Proper sleep hygiene is critical to the individual with chronic pain and often is hard to obtain. Various medications may provide short-term benefit. While sleeping pills, so-called minor tranquilizers, and anti-anxiety agents are commonly prescribed in chronic pain, pain specialists rarely, if ever, recommend them for long-term use. They can be habit-forming, and they may impair function and memory more than opioid pain relievers. There is also concern that they may increase pain and depression over the long-term. (Feinberg, 2008)" Also, regarding insomnia treatment: "Recommend that treatment be based on the etiology, with the medications recommended below. See Insomnia. Pharmacological agents should only be used after careful evaluation of potential causes of sleep disturbance. Failure of sleep disturbance to resolve in a 7 to 10 day period may indicate a psychiatric and/or medical illness. (Lexi-Comp, 2008) Primary insomnia is generally addressed pharmacologically. Secondary insomnia may be treated with pharmacological and/or psychological measures. The specific component of insomnia should be addressed: (a) Sleep onset; (b) Sleep maintenance; (c) Sleep quality; & (d) Next-day functioning." In this case, there is no evidence that his sleep problems have been fully evaluated and sleep hygiene measures have failed, necessitating the use of medication. The claimant's pattern of use and the benefit he gets from this medication, including functional improvement, have not been documented. There is no evidence that he has been involved in an ongoing exercise program to help maintain any benefit he receives from medication use. As a result, the medical necessity of Zolpidem 10mg #30 has not been clearly demonstrated.

Morphine Sulfate ER 30mg #90 x 3 refills: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids for Chronic Pain, Medications for Chronic Pain Page(s): 110, 94.

Decision rationale: The history and documentation do not objectively support the request for the opioid, morphine sulfate 30 mg #90 with 3 refills. The MTUS outlines several components of initiating and continuing opioid treatment and states "a therapeutic trial of opioids should not be employed until the patient has failed a trial of non-opioid analgesics. Before initiating therapy, the patient should set goals, and the continued use of opioids should be contingent on meeting these goals." In these records, there is no documentation of trials and subsequent failure of or intolerance to first-line drugs such as acetaminophen or nonsteroidal anti-inflammatory drugs. MTUS further explains, "pain assessment should include: current pain; the least reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid; how long it takes for pain relief; and how long pain relief lasts." There is also no indication that

periodic monitoring of the claimant's pattern of use and a response to this medication, including assessment of pain relief and functional benefit, has been or will be done. There is no evidence that he has been involved in an ongoing rehab program to help maintain any benefits he receives from treatment measures. Additionally, the 4A's "analgesia, activities of daily living, adverse side effects, and aberrant drug-taking behaviors" should be followed and documented per the guidelines. The claimant's pattern of use of morphine is unclear other than he takes it. There is no evidence that a signed pain agreement is on file at the provider's office and no evidence that a pain diary has been recommended and is being kept by the claimant and reviewed by the prescriber. No urine drug screens have been documented to support compliance. It appears that he may be taking it as needed. As such, the medical necessity of the ongoing use of morphine sulfate 30 mg #90 has not been clearly demonstrated.

Hydrocodone/Acetaminophen #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids for Chronic Pain, Medications for Chronic Pain Page(s): 110, 94.

Decision rationale: The history and documentation do not objectively support the request for the opioid, Hydrocodone-Acetaminophen, dosage unknown, #60. The MTUS outlines several components of initiating and continuing opioid treatment and states "a therapeutic trial of opioids should not be employed until the patient has failed a trial of non-opioid analgesics. Before initiating therapy, the patient should set goals, and the continued use of opioids should be contingent on meeting these goals." In these records, there is no documentation of trials and subsequent failure of or intolerance to first-line drugs such as acetaminophen or nonsteroidal anti-inflammatory drugs. MTUS further explains, "pain assessment should include: current pain; the least reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid; how long it takes for pain relief; and how long pain relief lasts." There is also no indication that periodic monitoring of the claimant's pattern of use and a response to this medication, including assessment of pain relief and functional benefit, has been or will be done. There is no evidence that he has been involved in an ongoing rehab program to help maintain any benefits he receives from treatment measures. Additionally, the 4A's "analgesia, activities of daily living, adverse side effects, and aberrant drug-taking behaviors" should be followed and documented per the guidelines. The claimant's pattern of use of morphine is unclear other than he takes it. There is no evidence that a signed pain agreement is on file at the provider's office and no evidence that a pain diary has been recommended and is being kept by the claimant and reviewed by the prescriber. No urine drug screens have been documented to support compliance. As such, the medical necessity of the ongoing use of Hydrocodone-Acetaminophen #60 has not been clearly demonstrated.

Naproxen 500mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs (non-steroidal anti-inflammatory drugs).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs
Page(s): 102.

Decision rationale: The history and documentation do not objectively support the request for continued use of naproxen 500 mg #60 for the claimant's ongoing pain. The MTUS state re: NSAIDs "Osteoarthritis (including knee and hip): Recommended at the lowest dose for the shortest period in patients with moderate to severe pain. Acetaminophen may be considered for initial therapy for patients with mild to moderate pain, and in particular, for those with gastrointestinal, cardiovascular or renovascular risk factors. NSAIDs appear to be superior to acetaminophen, particularly for patients with moderate to severe pain. There is no evidence to recommend one drug in this class over another based on efficacy. In particular, there appears to be no difference between traditional NSAIDs and COX-2 NSAIDs in terms of pain relief. The main concern of selection is based on adverse effects. COX-2 NSAIDs have fewer GI side effects at the risk of increased cardiovascular side effects, although the FDA has concluded that long-term clinical trials are best interpreted to suggest that cardiovascular risk occurs with all NSAIDs and is a class effect (with naproxen being the safest drug). There is no evidence of long-term effectiveness for pain or function. (Chen, 2008) (Laine, 2008) Back Pain -Acute exacerbations of chronic pain: Recommended as a second-line treatment after acetaminophen. Neuropathic pain: There is inconsistent evidence for the use of these medications to treat long-term neuropathic pain, but they may be useful to treat breakthrough and mixed pain conditions such as osteoarthritis (and other nociceptive pain) in with neuropathic pain." In this case, there is no evidence of osteoarthritis and no indication that this medication is being use for acute exacerbations of chronic back pain. The claimant's pattern of use of this medication is unclear, including when he takes it, what pain relief he receives, how long it lasts, or the objective measurable or functional benefit he receives from it. There is no evidence of significant inflammation to support its use prior to a trial of first line medication such as acetaminophen. The medical necessity of the use of naproxen 500 mg for ongoing pain in this case has not been clearly demonstrated.