

Case Number:	CM14-0162412		
Date Assigned:	10/07/2014	Date of Injury:	08/08/2008
Decision Date:	11/12/2014	UR Denial Date:	09/19/2014
Priority:	Standard	Application Received:	10/02/2014

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 Family 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:

This 61- year-old field mechanic reported injuries due to falling at work on 4/7/99, and then cumulative trauma injuries due to deskwork on 8/8/08. Treatment has included medications, physical therapy, massage, acupuncture, electrical stimulation, epidural steroid injections, lumbar spinal manipulation under anesthesia, cervical fusion, and revision of the cervical fusion and surgical implantation of a P STIM device. A third neck surgery to remove hardware is being contemplated. The most recent progress note in the records from the primary treater is dated 8/27/14. It documents that the patient complains of severe pain in his neck and R shoulder, which apparently worsened with implantation of the P STIM device. Physical findings include tenderness, decreased neck and back range of motion, and decreased sensation and strength in both upper and lower extremities. Diagnoses include degeneration/displacement of cervical disc, cervical radiculopathy, lumbar radiculopathy, and carpal tunnel syndrome. The treatment plan includes Norco 10/325 two per day #50, Soma 350 mg one at bedtime #30, Roxycodone 15 mg every 6 hours #100, and Xanax 1 mg three times per day #90. The treatment plan is confusing, and notes that Roxycodone has been decreased from 108 to 100 for 30 days, Norco 10/325 decreased from #54 to #50 for 30 days, and Xanax decrease from #90 to #45 for 30 days, apparently without changing the number of times the patient is to take these medications daily. These statements jive with the #50 Norco and the #100 Roxycodone dispensed, but not with the #90 Xanax dispensed. Review of the previous four notes reveals that on 4/2/14 the provider dispensed # 60 Norco 10, #30 Soma, #120 Roxycodone, and noted that Xanax was being prescribed by a psychiatrist. On 5/7/14 the provider noted "We will start wean 10% on narc meds". On that date #54 Norco 10, Soma 350 #30, and Roxycodone 15 mg #108 were dispensed. Xanax was noted as prescribed by a psychiatrist. On 6/4/14, #54 Norco 10, #30 Soma 350, and #108 Roxycodone 15 mg were dispensed, with another note stating that Xanax is being

prescribed by a psychiatrist. On 7/29/14 #50 Norc10, #30 Soma #350 mg, #100 Roxicodone 15 mg, and either #90 or #45 Xanax 1 mg were dispensed, with the same confusing statements as on 8/27/14. All of the notes contain confusing or contradictory statements about the number of medications dispensed and whether or not the patient is being weaned. Several of the notes contain the same statement as on 8/27/14 that Norco and Roxicodone are being decreased, though the number dispensed remains unchanged. Several of the notes simultaneously document "I can't wean this patient from his meds because he is still in a lot of pain" and "we are weaning meds for this chronic pain patient".

IMR ISSUES, DECISIONS AND RATIONALES

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

Soma 350 mg, QTY: 30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Carisoprodol (Soma) Page(s): 29. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Carisoprodol (Soma)

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Medications for Chronic Pain, Carisoprodol, Page(s): 60,29.

Decision rationale: Soma is brand-name Carisoprodol, which is a centrally acting skeletal muscle relaxant. According to the first guideline cited above, medications should be started individually while other treatments are held constant, with careful assessment of function. There should be functional improvement with each medication in order to continue it. The second guideline states that Carisoprodol is not recommended, and is not indicated for long-term use. Its primary metabolite, meprobamate, is a controlled substance. Carisoprodol has substantial abuse potential. It also may augment the effects of other drugs including benzodiazepines and hydrocodone. Some abusers claim that the combination of Carisoprodol and hydrocodone produces effects that are similar to those of heroin. The records in this case reveal that this patient has been on Soma for a very long time. An 815/11 AME report lists Soma among the patient's current medications. This patient has been totally disabled since August 2008, and there is documented evidence that Soma has improved his level of function in any way. Given its sedating effects, especially in combination with several of the other medications he is taking, it seems quite likely that Soma is contributing to this patient's low functional level. Taking the evidence-based guidelines cited above, being not recommended by MTUS guidelines and the clinical finding in this case into account, Soma 350 mg #30 is not medically necessary.

Roxicodone 15 mg, QTY: 100: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Medications for Chronic Pain, and Criteria for use of Opioids, Opioid ,Hyperalgesia, Page(s):.

Decision rationale: Roxicodone is brand-name oxycodone, which is an opioid analgesic. The first guideline cited above states that medications should be started individually while other treatments are held constant, with careful assessment of function. There should be functional improvement with each medication in order to continue it. Per the second guideline, Opioids should not be started without an evaluation of the patient's current status in terms of pain control and function. An attempt should be made to determine if the patient's pain is nociceptive or neuropathic. Red flags indicating that opioid use may not be helpful should be identified, as should risk factors for abuse. Specific goals should be set, and continued use of opioids should be contingent on meeting these goals. Opioids should be discontinued if there is no improvement in function or if there is a decrease in function. The third guideline states that opioids are not recommended as first-line therapy for neuropathic pain. The response of neuropathic pain to drugs may depend on the cause of the pain. There are very limited numbers of studies that involve opioid treatment for chronic lumbar root pain. A recent study found that chronic radicular lumbar pain did not respond to opioids in doses that have been effective for painful diabetic neuropathy and postherpetic neuralgia. The last guideline states that patients taking opioids sometimes develop abnormal pain, a change in pain pattern, or persistence in pain at higher levels than expected, which are actually a result of taking opioids. This is called opioid hyperalgesia. Opioid hyperalgesia should be screened for, as it actually may require weaning off opioids rather than increasing doses. The clinical findings in this case do not support the continued use of Roxicodone. There is no documentation of an appropriate evaluation of this patient in regards to whether or not opioid use was likely to be helpful to him, and whether or not he is at risk for aberrant drug behavior. No specific functional goals were set or are being followed. There was no attempt to evaluate the patient for opioid hyperalgesia when he had persistent high levels of pain. Finally, Roxicodone has not been discontinued when it became clear that its use did not result in any functional improvement. The patient remains totally disabled, and has been so for years. Although this provider claims to be weaning the patient off Roxicodone, he has not documented a clear plan for doing so, and many of his notes state that he is unable to do so. The number of Roxicodone 15 mg dispensed has apparently decreased from 120 per month to 100 per month over the period from 5/7/14 to 8/27/14. This is a very slow decrease, and it is unclear how the patient was instructed to accomplish it, since he is still being advised to take Roxicodone four times per day. The 8/27/14 note does not make it clear that the provider plans to continue tapering. According to the evidence-based guidelines cited above and the clinical findings in this case, Roxicodone 15 mg, #100 is not medically necessary.

Xanax 1 mg, QTY: 90: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Medications for Chronic Pain, and Benzodiazepines Page(s): 60,24.

Decision rationale: According to the guidelines cited above, medications should be started individually while other treatments are held constant, with careful assessment of function. There should be functional improvement with each medication in order to continue it. Benzodiazepines (of which Xanax is one) are not recommended for long-term use for multiple reasons. Their long-term efficacy is unproven, and there is a risk of dependence. Tolerance to hypnotic effects

occurs rapidly, and tolerance to anxiolytic effects occurs within months. Long-term use may actually increase anxiety. In this case, Xanax has been prescribed for a very long time, apparently always in conjunction with other medications. There is an AME evaluation from 10/20/09 documenting that the patient was taking Xanax. There has been no assessment of baseline function and no functional goals have been set. It is clear that this patient has had no functional improvement as a result of taking Xanax--he has remained totally disabled. The documentation of the current provider is at its most incoherent in regards to Xanax. Several notes state that Xanax is being prescribed by a psychiatrist, then the last two available notes document cutting the amount of Xanax from 90 to 45 per month, but dispensing 90. Neither the evidence-based guidelines cited above nor the clinical findings in this case support the ongoing use of Xanax for this patient. Therefore the request for Xanax 1 mg #90 is not medically necessary.