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| Case Number: | CM15-0011248 | | |
| Date Assigned: | 01/28/2015 | Date of Injury: | 02/10/1998 |
| Decision Date: | 03/23/2015 | UR Denial Date: | 12/31/2014 |
| Priority: | Standard | Application Received: | 01/20/2015 |

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: California

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:

This 58-year-old heavy equipment machinist reported neck and low back injuries after a lifting a heavy pipe overhead on 2/10/98. Current diagnoses include chronic low back pain with radicular symptoms, chronic pain syndrome and cervical post laminectomy syndrome. Treatment to date has included two neck surgeries and oral pain medications. The current treating provider first saw the patient on 8/29/14. At the time the patient reported he was no longer taking Norco, which had been prescribed by his previous provider. The current treater noted that the patient "had significant pain off medications" and dispensed Norco 10/325 #120 to be taken four times per day. In addition he prescribed tapendolol for night use. A urine drug screen was performed the same day which was positive for hydrocodone, which was inconsistent. The provider never commented on this result. On subsequent visits the provider increased the Norco 10/325 to 6 per day, discontinued tapendolol, and started cyclobenzaprine 7.5 mg twice per day as well as tramadol ER 1-2 per day as needed. The patient was described as quite active and able to take care of his house and yard as well as to take walks beginning at the 8/29/14 visit. This activity level did not change, but the provider subsequently stated that the patient's pain medications were what allowed him to perform these activities. The patient remained off work during August through December of 2014, and no plans to return to work were mentioned. In a progress note dated 12/18/2014 the injured worker was noted to report continued neck and low back pain radiating to the posterior legs that was rated as 8-9/10 without medication and 7-8 with medication. Objective physical examination findings were notable for mild tenderness of the cervical paraspinal muscles, decreased range of motion and decreased sensation in the hands,

moderate tenderness in the paraspinal muscles with decreased range of motion and positive straight leg raise on the left. The physician requested authorization for refills of Tramadol and Norco. On 12/31/2014, Utilization Review modified a request for Tramadol from 150 mg ER daily #60 to Tramadol 150 mg ER daily #30 and modified a request for Norco from Norco 10/325 mg every 4 hours as needed #180 to Norco 10/325 mg every 4 hours as needed #60, noting that there was no documentation of which specific medications provided pain relief and that the medication should be weaned. MTUS guidelines were cited.

IMR ISSUES, DECISIONS AND RATIONALES

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

Tramadol 150 mg ER daily #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use Page(s): 78.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Medications for Chronic Pain, page 60, Criteria for Use of Opioids, Steps to Take Before a Thera. Decision based on Non-MTUS Citation UptoDate, an online evidence-based review service for clinicians (www.uptodate.com), Tramadol: Drug Information

Decision rationale: Tramadol is an opioid analgesic. Per the MTUS recommendations cited above, medications should be trialed one at a time while other treatments are held constant, with careful assessment of function, and there should be functional improvement with each medication in order to continue it. 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 functional 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. 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. Per the UptoDate reference cited above, tramadol increases the risk of seizures even at recommended doses. This risk is increased in patients on other opioids or cyclobenzaprine. The clinical documentation in this case does not support the use of tramadol for this patient. The provider has documented that the patient has a combination of nociceptive and neuropathic pain. Neuropathic pain does not necessarily respond well to opioids, and does not appear to have done so in this case. No assessment was made of whether or not opioid use was likely to be helpful in this patient, or of his potential for abuse. A major red flag regarding abuse was ignored by the provider when the initial drug screen was positive for hydrocodone at a time when the patient reported he was not taking Norco. No specific functional goals were set or followed. Importantly, tramadol was not discontinued when it became clear that it has not produced any functional improvement. This patient's functional level does not appear to have improved in any way since tramadol was introduced. Although he is reported as being somewhat active, his level of activity has not changed since starting tramadol, and he remains off work. The patient continues to take cyclobenzaprine. As discussed above, this patient's risk of having a seizure is increased by the

combination of tramadol with cyclobenzaprine. Every progress note in the records documents that he had a seizure due to Keflex, which probably means that he has a seizure diathesis. The combination of tramadol and cyclobenzaprine is particularly dangerous in this case. Based on the clinical information available for my review and on the evidence-based citations above, tramadol ER 150 mg #60 is not medically necessary. It is not medically necessary because no appropriate evaluation of the patient was made before it was started, because no functional goals for its use were set or monitored, because its use has not resulted in any functional recovery, because its combination with cyclobenzaprine puts the patient at risk for seizures, and because the patient appears to have aberrant drug behavior which has not been addressed.

Norco 10/325 mg q 4 hours PRN #180: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use Page(s): 78.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Medications for Chronic Pain, page 60, Criteria for Use of Opioids, Steps to Take Before a Thera.

Decision rationale: Norco 10/325 is brand-name hydrocodone 10 mg with acetaminophen 325 mg. Hydrocodone is an opioid analgesic. Per the MTUS recommendations cited above, medications should be trialed one at a time while other treatments are held constant, with careful assessment of function, and there should be functional improvement with each medication in order to continue it. 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 in 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 functional 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. 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. Per the UptoDate reference cited above, tramadol increases the risk of seizures even at recommended doses. This risk is increased in patients on other opioids or cyclobenzaprine. The clinical documentation in this case does not support the use of Norco for this patient. The provider has documented that the patient has a combination of nociceptive and neuropathic pain. Neuropathic pain does not necessarily respond well to opioids, and does not appear to have done so in this case. No assessment was made of whether or not opioid use was likely to be helpful in this patient, or of his potential for abuse. A major red flag regarding abuse was ignored by the provider when the initial drug screen was positive for hydrocodone at a time when the patient reported he was not taking Norco. No specific functional goals were set or followed. Importantly, Norco was not discontinued when it became clear that it has not produced any functional improvement. This patient's functional level does not appear to have improved in any way since tramadol was introduced. Although he is reported as being somewhat active, his level of activity has not changed since starting Norco, and he remains off work. Based on the clinical information available for my review and on the evidence-based citations above, Norco 10/325 mg #180 is not medically necessary. It is not medically necessary because no appropriate evaluation of the patient was made before it was

started, because no functional goals for its use were set or monitored, because its use has resulted in no functional recovery, and because the patient appears to have aberrant drug behavior which has not been addressed.