

Case Number:	CM15-0114139		
Date Assigned:	06/22/2015	Date of Injury:	09/25/2003
Decision Date:	07/27/2015	UR Denial Date:	05/21/2015
Priority:	Standard	Application Received:	06/12/2015

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: New York
 Certification(s)/Specialty: Anesthesiology

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 60 year old male who sustained an industrial injury on 9/25/03 when he fell backwards off of a ladder injuring his head, neck and low back. He has had multiple orthopedists, management specialists, surgical procedures to the neck and low back, invasive pain management interventions, narcotic pain medications. He complains of chronic cervical, bilateral shoulder and low back pain radiating down both lower extremities. In addition he has low testosterone as a result of long-term opiate medication. His physical exam was unremarkable (5/4/15). Since his right L2-3 and L3-4 radio frequency neurotomy (10/29/14) he has had a 50% reduction in low back pain and was able to reduce his pain medication by 30%. Medications provide functional gains and assist in activities of daily living, mobility and provide restorative sleep. Medications are Fentanyl patch, hydrocodone-acetaminophen, Pamelor, Soma, Senekot. He had a drug screen on 11/13/14. Diagnoses include cervical spondylosis; status post anterior cervical fusion at C3-4 and C4-5; cervical laminectomy syndrome; displacement of cervical intervertebral disc without myelopathy; displacement of lumbar intervertebral disc without myelopathy; thoracic or lumbosacral neuritis or radiculitis; disorders of the back. Treatments to date include daily gym attendance; medications; pain management evaluation (3/5/15); transcutaneous electrical nerve stimulator unit, which was helpful. Diagnostics include MRI of the cervical spine (no date) showing degenerative disc disease and mild stenosis. In the progress noted dated 5/4/15 the treating provider's plan of care includes requests for Fentanyl patch 12 mcg/hr. one every 72 hours; Soma 350 mg one as

needed for spasms at bedtime; hydrocodone-acetaminophen 10/325 mg as needed for breakthrough pain; Pamelor 10 mg as needed at bedtime.

IMR ISSUES, DECISIONS AND RATIONALES

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

Hydrocodone/Acetaminophen 10/325mg, #150: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use, On-going Management; Opioids, specific drug list Page(s): 78, 91.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids for the treatment of chronic pain Page(s): 91-97. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Opioids.

Decision rationale: According to the CA MTUS and ODG, Norco 10/325mg (Hydrocodone/Acetaminophen) is a short-acting opioid analgesic indicated for moderate to moderately severe pain, and is used to manage both acute and chronic pain. The treatment of chronic pain with any opioid analgesic requires review and documentation of pain relief, functional status, appropriate medication use, and side effects. A pain assessment should include current pain, intensity of pain after taking the opiate, and the duration of pain relief. In this case, there is no documentation of the medication's functional benefit. Medical necessity of the requested item has not been established. Of note, discontinuation of an opioid analgesic should include a taper, to avoid withdrawal symptoms. The requested medication is not medically necessary.

Fentanyl 12mcg/hr Transdermal Patch, #10: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Fentanyl; Opioids, specific drug list, Fentanyl transdermal Page(s): 47, 93. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Chapter, Fentanyl.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids for the treatment of chronic pain Page(s): 91-97.

Decision rationale: According to the ODG and MTUS, Fentanyl is a long-acting narcotic analgesic used to manage both acute and chronic pain. Fentanyl is an opioid analgesic with a potency of eighty times that of Morphine. Fentanyl transdermal (Duragesic) patches are indicated for the management of persistent chronic pain, which is moderate to severe requiring continuous, around-the-clock opioid therapy. Duragesic patches should only be used in patients who are currently on opioid therapy for which tolerance has developed. Patches are worn for a 72-hour period. In this case, the treatment of chronic pain with any opioid analgesic requires review and documentation of pain relief, functional status, appropriate medication use, and side effects. A pain assessment should include current pain, intensity of pain after taking the opiate, and the duration of pain relief. There is no documentation of the medication's pain relief effectiveness, functional status, or response to ongoing opioid analgesic therapy. Medical

necessity of the requested item has not been established. Of note, discontinuation of an opioid analgesic should include a taper to avoid withdrawal symptoms. The requested medication is not medically necessary.

Pamelor 10mg, #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressants for chronic pain Page(s): 13.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressants Page(s): 24,80. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Antidepressants for chronic pain, Tricyclic antidepressants.

Decision rationale: Antidepressants for chronic pain are recommended as a first line option for neuropathic pain, and as a possibility for non-neuropathic pain. Tricyclic antidepressants, such as Nortriptyline (Pamelor), are generally considered a first-line agent unless they are ineffective, poorly tolerated, or contraindicated. Analgesia generally occurs within a few days to a week, whereas antidepressant effect takes longer to occur. In addition, recent reviews recommended tricyclic antidepressants as a first-line option, especially if pain is accompanied by insomnia, anxiety, or depression. Indications in controlled trials have shown effectiveness in treating central post-stroke pain, post-herpetic neuralgia, painful diabetic and non-diabetic polyneuropathy, and post-mastectomy pain. Tricyclics are contraindicated in patients with cardiac conduction disturbances and/or decompensation (they can produce heart block and arrhythmias) as well as for those patients with epilepsy. For patients > 40 years old, a screening EKG is recommended prior to initiation of therapy. In this case, there is no documentation of objective functional improvement as a result of this medication. There is no documentation of medical need to continue Pamelor. Medical necessity for the requested medication has not been established. The requested medication is not medically necessary.

Carisoprodol (Soma) 350mg, #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain) Page(s): 65. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Chapter, Carisoprodol (Soma).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants Page(s): 29, 63.

Decision rationale: The CA MTUS does not recommend muscle relaxants for chronic pain. Non-sedating muscle relaxants are an option for short term exacerbations of chronic low back pain. Carisoprodol (Soma) is the muscle relaxant requested in this case. This medication is sedating. No reports show any specific and significant improvements in pain or function as a result of prescribing muscle relaxants. According to the MTUS guidelines, Soma is categorically not recommended for chronic pain, noting its habituating and abuse potential. Medical necessity for the requested medication has not been established. The requested medication is not medically necessary.