

<b>Case Number:</b>	CM15-0120609		
<b>Date Assigned:</b>	07/01/2015	<b>Date of Injury:</b>	07/02/1996
<b>Decision Date:</b>	08/05/2015	<b>UR Denial Date:</b>	05/22/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/22/2015

### 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: Pennsylvania  
 Certification(s)/Specialty: Internal Medicine

### 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 64-year-old female with a reported date of injury of 07/02/1996. The mechanism of injury was not included in the medical records provided for review. The injured worker's symptoms at the time of the injury were not indicated. The diagnoses include cervical radiculitis, lumbar radiculopathy, status post lumbar spine fusion, chronic pain, and status post aortic valve replacement. Treatments and evaluation to date have included an intrathecal pump, spinal cord stimulator, and oral medications. The pain medicine re-evaluation dated 01/21/2015 indicates that the injured worker's pain was rated 6 out of 10 on average with medications since the last visit; and rated 9 out of 10 on average without medications since the last visit. It was noted that her pain was reported as unchanged since the last visit. The pain medicine re-evaluation dated 04/29/2015 indicates that the injured worker complained of neck pain with radiation down the left upper extremity; and low back pain with radiation down the right lower extremity. She also complained of frequent and severe muscle spasms in the low back. The pain was rated 7 out of 10 on average with medications since the last visit; and rated 9 out of 10 on average without medications since last visit. The injured worker's pain was reported as unchanged since her last visit. She reported ongoing activity of daily living limitation due to pain. The limitations were in the following areas: self-care and hygiene, activity, walking, hand function, and sleep. The physical examination showed tenderness of the right buttocks; tenderness in the cervical spine at C5-7; limited cervical spine range of motion due to pain; increased pain with flexion, extension, and rotation of the cervical spine; spasm in the lumbar paraspinous musculature; moderately limited lumbar spine range of motion due to pain;

increased pain with flexion and extension of the lumbar spine; and decreased sensitivity to touch along the L5-S1 dermatome in the right lower extremity. The injured worker complained of ongoing pain at the right gluteal spinal cord stimulator battery site, and stated that it interfered with prolonged sitting. She requested the immediate removal of the battery and leads. The injured worker was not currently working; her last date of work was in 1994. She was permanently disabled. The plan was to follow-up with the injured worker in three months for re-evaluation. Treatment goals and objectives were developed with the injured worker. It was documented that the injured worker was monitored by periodic urinary drug testing and CURES reporting. The treating physician requested Percocet with two refills, Flexeril with two refills, and Naloxone/Evzio.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**Percocet 10/325mg #60 with 2 refills: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Specific Drug List, Oxycodone/Acetaminophen, Opioids, Criteria for Use.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74-96.

**Decision rationale:** The CA MTUS Chronic Pain Guidelines indicate that opioids are minimally indicated, if at all, for chronic non-specific pain, osteoarthritis, "mechanical and compressive etiologies," and chronic back pain. The injured worker had been receiving treatment for chronic neck and low back pain with radiation of pain. Opioids have been prescribed since 10/02/2013. The CA MTUS guidelines indicate that on-going management for the use of opioids should include the on-going review and documentation of pain relief, functional status, appropriate medication use, and side effects. Ongoing management should reflect four domains of monitoring, including analgesia, activities of daily living, adverse side effects, and aberrant drug-taking behaviors. There was documentation that the injured worker experienced a reduction in pain; however, pain severity rating was not changed. Although the physician stated that the injured worker demonstrated an improvement in level of function, work status remained not working and there was no documentation of improvements in specific activities of daily living. The physician noted that she did not experience side effects, that she complied with the pain management agreement and that there were no signs of medication abuse or diversion; however, no urine drug screens were submitted. The pain assessment should include: current pain, the least reported pain over the period since the last assessment, average pain, intensity of pain after taking the opioid, how long it takes for pain relief, and how long the pain relief lasts. Such a detailed pain assessment was not submitted. Therefore, the request for Percocet is not medically necessary.

**Flexeril 10mg #50 with 2 refills: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Cyclobenzaprine (Flexeril), Muscle Relaxants (for pain).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Cyclobenzaprine (Flexeril) and Muscle relaxants (for pain) Page(s): 41-42 and 63-66.

**Decision rationale:** The CA MTUS Chronic Pain Guidelines recommend non-sedating muscle relaxants with caution as a second-line option for short-term treatment of acute exacerbations in patients with chronic low back pain. Cyclobenzaprine (Flexeril) is a skeletal muscle relaxant, and its side effects include drowsiness, urinary retention, and dry mouth. The medication is associated with drowsiness and dizziness. The guidelines indicate that the effectiveness of muscle relaxants appear to diminish over time and prolonged use of the some medications in this class may lead to dependence. The guidelines indicate that "treatment should be brief." The treatment plan included a slow weaning of Flexeril; however the medication has been prescribed since 10/02/2013. The guidelines recommend Cyclobenzaprine for a short course of therapy. This medication is not recommended to be used for longer than 2-3 weeks. Due to length of use far in excess of the guideline recommendations, the request for Flexeril is not medically necessary.

**Naloxone 0.4mg/0.4ml Evzio prefilled syringe #1:** 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 Opioids Page(s): 74-96. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) pain chapter: naloxone, evzio.

**Decision rationale:** Evzio is an FDA-approved naloxone drug-device combination indicated for the emergency treatment of opioid overdose. The device is designed to guide an untrained lay user through the process of use for overdose reversal. The MTUS states that naloxone is an opioid antagonist which is used most often to reverse the effects of agonists and agonist-antagonist-derived opioids. Naloxone is recommended in hospital-based and emergency department settings to address opioid overdose cases. It is recommended on a case-by-case basis for outpatient pre hospital use for patients who are prescribed opioids. The Official Disability Guidelines citation above addresses this kind of naloxone prescription, and has a long and detailed list of criteria for prescription. These criteria include documentation of a complete history that includes questions about prior drug and alcohol use, including previous overdose, recent detoxification or abstinence from drugs, results of a screening tool for potential prescription drug abuse, a complete list of chronic medical illnesses, and a complete medication list. Extensive additional criteria are listed for consideration for use of naloxone, and include active abusers of scheduled drugs, history of substance abuse, patients on methadone or buprenorphine maintenance, patients on high dose of opioids, and other criteria as per the guidelines. A generic formulation is recommended; branded products such as Evzio are only recommended if generic are not available. This injured worker did not meet the criteria as discussed in the ODG for consideration of prescription of naloxone. Detailed history of prior drug and alcohol use and results of a screening tool for potential prescription drug abuse were not documented. There was no history of substance abuse, use of high dose opioids, or location remote from access to emergency care. As such, the request for naloxone/Evzio is not medically necessary.