

<b>Case Number:</b>	CM15-0129987		
<b>Date Assigned:</b>	07/16/2015	<b>Date of Injury:</b>	05/04/2006
<b>Decision Date:</b>	09/23/2015	<b>UR Denial Date:</b>	06/09/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/06/2015

### 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: Colorado  
 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:

The injured worker is a 66 year old male, who sustained an industrial injury on 5/4/2006. The injured worker was diagnosed as having chronic cervical myofascial mechanical pain with flare ups, cervical disc protrusion, chronic right cervical radicular syndrome with flare up, underlying cervical degenerative disc and joint disease, cervical spine dysfunction. Treatment to date has included medications, and exercise program. Acupuncture and physical therapy have been requested, though records do not indicate if approved/completed. Some of the medical records have handwritten information which is difficult to decipher. In several clinic visits between 8/8/2014 and 8/20/2014, he complained of chest discomfort/back pain rated 6/10, and neck pain rated 4/10. On 5/21/2015, he reported feeling the same as previously and rated his neck pain 7/10. Also at that visit, patient stated there is numbness and tingling in his hands and has no new symptoms or changes, except for the last month he felt some increased pain due to work outs at the gym. Physical findings on 5/21/2015 include restricted cervical spine range of motion, tenderness over the right trapezius, splenius, semispinalis areas, and a positive spurling maneuver, tenderness in the bilateral upper extremities, full range of motion of the bilateral shoulder, elbows and wrists, no sensory abnormalities noted with the upper extremities, positive Tinel and Phalen tests on the right and negative on the left. The treatment plan included: refill Norco and initiation of Soma and a trial of Medrol pack; and acupuncture and physical therapy.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Prednisone 10mg #42: Upheld**

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation MEDLINE literature review: Drug therapy for back pain. Which drugs help which patients, Deyo RA. Spine (Phila Pa 1976). 1996 Dec 15; 21(24): 2840-9; discussion 2849-50. Effect of facet joint injection versus systemic steroids in low back pain: a randomized controlled trial. Ribeiro LH, Vilar Furtado IN, Konai MS, Rosenfeld A, Andreo AB, Natour J. Spine (Phila Pa 1976). 2013 Nov 1; 38(23): 1995-2002. doi: 10.1097/BRS.0b013e3182a76df1. Steroids for LBP-from rationale to inconvenient truth. Balagu© F1, Piguet V, Dudler J. Swiss Med Wkly. 2012 Apr 11; 142: w13566. doi: 10.4414/smw.2012.13566. Oral prednisolone in the treatment of cervical radiculopathy: A randomized placebo controlled trial. Ghasemi M1, Masaeli A, Rezvani M, Shaygannejad V, Golabchi K, Norouzi R. J Res Med Sci. 2013 Mar; 18(Suppl 1): S43-6.

**Decision rationale:** The MTUS Guidelines do not address prednisone, or steroid class, so review of available research/analysis in MEDLINE was conducted for evidence-based recommendations. Per MEDLINE search, there is insufficient evidence in the literature to support use of systemic corticosteroids for acute or chronic pain. No large scale, quality research studies in human trials have shown improvement in back pain/neck pain when compared to placebo, local steroids, and/or non-steroidal anti-inflammatory drugs. (A single small study did show some improvement in neck pain with short term oral steroids, but this does not meet the level of evidence-based criteria.) The request for Prednisone is not medically necessary as no recommendation exists to support its use in this patient.

**Norco 5/325mg #60: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 12 Low Back Complaints, Chronic Pain Treatment Guidelines Hydrocodone/Acetaminophen, Criteria for use of opioids.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Pain Interventions and Treatments Page(s): 79-80, 85, and 88-89.

**Decision rationale:** The Guidelines establish criteria for use of opioids, including long term use (6 months or more). When managing patients using long term opioids, the following should be addressed: Re-assess the diagnosis and review previous treatments and whether or not they were helpful. When re-assessing, pain levels and improvement in function should be documented. Pain levels should be documented every visit. Function should be evaluated every 6 months using a validated clinical assessment tool. Adverse effects, including hyperalgesia, should also be addressed each visit. Patient's motivation and attitudes about pain/work/interpersonal relationships can be examined to determine if patient requires psychological

evaluation as well. Aberrant/addictive behavior should be addressed if present. Do not decrease dose if effective. Medication for breakthrough pain may be helpful in limiting overall medication. Follow up evaluations are recommended every 1-6 months. To summarize the above, the 4As of Drug Monitoring (analgesia, activities of daily living, adverse side effects, and aberrant drug-taking Behaviors) have been established. The monitoring of these outcomes over time should affect therapeutic decisions and provide a framework for documentation of the clinical use of these controlled drugs. (Passik, 2000) Several circumstances need to be considered when determining to discontinue opioids: 1) Verify patient has not had failure to improve because of inappropriate dosing or under-dosing of opioids. 2) Consider possible reasons for immediate discontinuation including diversion, prescription forgery, illicit drug use, suicide attempt, arrest related to opioids, and aggressive or threatening behavior in clinic. Weaning from the medication over 30 day period, under direct medical supervision, is recommended unless a reason for immediate discontinuation exists. If a medication contract is in place, some physicians will allow one infraction without immediate discontinuation, but the contract and clinic policy should be reviewed with patient and consequences of further violations made clear to patient. 3) Consider discontinuation if there has been no improvement in overall function, or a decrease in function. 4) Patient has evidence of unacceptable side effects. 5) Patient's pain has resolved. 6) Patient exhibits "serious non-adherence" or misuse. Per the Guidelines, Chelminski defines "serious substance misuse" as meeting any of the following criteria: (a) cocaine or amphetamines on urine toxicology screen (positive cannabinoid was not considered serious substance abuse); (b) procurement of opioids from more than one provider on a regular basis; (c) diversion of opioids; (d) urine toxicology screen negative for prescribed drugs on at least two occasions (an indicator of possible diversion); & (e) urine toxicology screen positive on at least two occasions for opioids not routinely prescribed. (Chelminski, 2005) 7) Patient requests discontinuing opioids. 8) Consider verifying that patient is in consultation with physician specializing in addiction to consider detoxification if patient continues to violate the medication contract or shows other signs of abuse/addiction. 9) Document the basis for decision to discontinue opioids. Likewise, when making the decision to continue opioids long term, consider the following: Has patient returned to work? Has patient had improved function and decreased pain with the opioids? Per the records for the patient of concern, he has not had measureable improvement in pain over the months (at least 9 months) he has been on Norco, and has had no documented improvement in function with his current regimen which includes Norco. There are no documented discussions of the risks of long term opioid use, or discussion of the possible side effects. There is no evidence that patient has had monitoring for abuse of opioids. Without evidence that the patient has improved with regard to function and pain on opioids, and without evidence that appropriate monitoring of opioid use is ongoing, the Norco refill request is not medically necessary.

**Soma 350mg #60:** 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 Pain Interventions and Treatments Page(s): 29, 63, 65.

**Decision rationale:** Per the Guidelines, muscle relaxants, comprised of anti-spasmodics and anti-spasticity drugs, can be recommended as second line, short term options for treatment of low back pain. Studies suggest that muscle relaxants can decrease pain and muscle tension, thereby improving mobility/flexibility. However, the studies do not show any benefit of muscle relaxants over non-steroidal anti-inflammatory drugs, or in combination with non-steroidal anti-inflammatory drugs, for low back pain. The effects of muscle relaxants appear to decrease over time, and none of the anti-spasmodics are recommended for use longer than 2-3 weeks. Long term use of some of the muscle relaxants, including Carisoprodol (Soma), may result in dependence. While Carisoprodol is one of the most commonly prescribed muscle relaxants, it is not recommended for use per the Guidelines, due to its potential for abuse. Carisoprodol is metabolized to meprobamate, a schedule IV substance. Carisoprodol is abused for its own effects, but it has also been shown to alter the effects of other drugs such as: (1) increasing sedation of benzodiazepines or alcohol; (2) use to prevent side effects of cocaine; (3) use with tramadol to produce relaxation and euphoria; (4) as a combination with hydrocodone, an effect that some abusers claim is similar to heroin (referred to as a "Las Vegas Cocktail"); & (5) as a combination with codeine (referred to as "Soma Coma"). (Reeves, 1999) (Reeves, 2001) (Reeves, 2008) (Schears, 2004) There was a 300% increase in numbers of emergency room episodes related to carisoprodol from 1994 to 2005. (DHSS, 2005) Carisoprodol has also been shown to have a withdrawal syndrome characterized by insomnia, vomiting, tremor, muscle twitches, anxiety, and ataxia, with no known treatment for patients with dependence. Carisoprodol was approved before FDA required proof of efficacy and safety. Based on the Guidelines, Carisoprodol (Soma) is not a recommended medication for use in pain management. The request for Soma is not medically necessary.