

<b>Case Number:</b>	CM15-0171574		
<b>Date Assigned:</b>	09/14/2015	<b>Date of Injury:</b>	10/29/2012
<b>Decision Date:</b>	10/15/2015	<b>UR Denial Date:</b>	08/14/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/31/2015

### 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: North Carolina

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 injured worker is a 56 year old female who reported an industrial injury on 10-29-2012. Her diagnoses, and or impression, were noted to include: lumbosacral neural encroachment with radiculopathy, refractory; left-sided lumbosacral protrusion with severe lumbar spinal stenosis and bilateral lumbar radiculopathy; and progressive psychological depression. Toxicology screenings were noted on 3-4-2015, 3-20-2015 & 4-15-2015; no current imaging studies were noted. Her treatments were noted to include: an impairment rating on 5-27-2015; a panel qualified medical re-evaluation on 5-28-2015, with supplemental report on 6-29-2015; trans-cutaneous electrical nerve stimulation unit therapy; a back brace for stability; medication management with toxicology screenings and DNA-genetic testing for medication selection - noting a contraindication to Morphine; and rest from work. The orthopedic progress notes of 2-11-2015 reported a follow-up consultation for severe, 8 out of 10, low back pain with left > right lower extremity symptoms; that her medication at its current dosing, including Tramadol Extended Release 300 mg 1 or 2 per day, facilitated maintenance of activities of daily living (ADL's), and that without medication, her ADL's and daily exercise regimen were in jeopardy. The objective findings were noted to include: improved ADL's and functionality on Tramadol 300 mg 1 or 2 per day; tenderness over the lumbar spine with specific degrees of lumbar range-of-motion; positive bilateral straight leg raise; diminished sensation, left > right, in the lumbosacral dermatome distributions; spasms in the lumbo-paraspinal musculature; difficulty arising from seated position; noted discomfort, with shifting about, in the chair and on the exam table; and a continued decline of her lumbar condition. The physician's requests for treatments were noted to include Tramadol Extended Release (ER) 150 mg, 2 per day, #60. The orthopedic progress notes of 3-4-2015 noted mostly the same subjective reports as the 2-11-2015 progress

notes, with the addition of the injured workers inquiry to the requested surgery, and of continued complaints of instability with near, and actual, falls; no significant changes in objective findings; that Tramadol ER 300 mg 1 or 2 per day resulted in an approximate 5 point diminution in pain depending on the activity level, and improved function at current dosing; and that Tramadol ER 150 mg, 2 per day, #60 was dispensed. The orthopedic progress notes of 6-11-2015 noted that she consumed Hydrocodone when necessary for severe pain. No Request for Authorization for Keflex 500 mg #28, Norco 10-325 mg #60, and Tramadol 50 mg #60 was noted in the medical records provided. The Utilization Review of 8-14-2015 non-certified the request for Keflex 500 mg #28, Norco 10-325 mg #60, and Tramadol 50 mg #60.

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

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

**Keflex 500mg, #28:** 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 PDR, keflex.

**Decision rationale:** The ACOEM and the California MTUS does not address the requested service. The physician desk reference states the requested medication is indicated in the treatment of acute infections. The patient does not have documentation physical exam that would medically warrant this request. Therefore, it is not medically necessary.

**Norco 10/325mg, #60:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Medications for chronic pain.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids for chronic pain.

**Decision rationale:** The California chronic pain medical treatment guidelines section on opioids states for ongoing management: On-Going Management. Actions Should Include: (a) Prescriptions from a single practitioner taken as directed, and all prescriptions from a single pharmacy. (b) The lowest possible dose should be prescribed to improve pain and function. (c) Office: Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. Pain assessment should include: current pain; the least reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid; how long it takes for pain relief; and how long pain relief lasts. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. Information from family members or other caregivers should be considered in determining the patient's response to treatment. The 4 A's for Ongoing Monitoring: Four domains have been proposed as most relevant for ongoing monitoring of chronic pain patients on opioids: pain relief, side-effects, physical and psychosocial functioning, and the occurrence of any potentially aberrant (or non-adherent) drug-related behaviors. These domains have been summarized as the "4 A's" (analgesia, activities of daily living, adverse side effects, and aberrant drug taking behaviors). 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). (d) Home: To aid in pain and functioning assessment, the patient should be requested to keep a pain diary that includes entries such as pain triggers, and incidence of end-of-dose pain. It should be emphasized that using this diary will help in tailoring the opioid dose. This should not be a requirement for pain management. (e) Use of drug screening or inpatient treatment with issues of abuse, addiction, or poor pain control. (f) Documentation of misuse of medications (doctor-shopping, uncontrolled drug escalation, drug diversion). (g) Continuing review of overall situation with regard to non-opioid means of pain control. (h) Consideration of a consultation with a multidisciplinary pain clinic if doses of opioids are required beyond what is usually required for the condition or pain does not improve on opioids in 3 months. Consider a psych consult if there is evidence of depression, anxiety or irritability. Consider an addiction medicine consult if there is evidence of substance misuse. When to Continue Opioids; (a) If the patient has returned to work. (b) If the patient has improved functioning and pain. (Washington, 2002) (Colorado, 2002) (Ontario, 2000) (VA/DoD, 2003) (Maddox-AAPM/APS, 1997) (Wisconsin, 2004) (Warfield, 2004). The long-term use of this medication class is not recommended per the California MTUS unless there documented evidence of benefit with measurable outcome measures and improvement in function. There is no documented significant decrease in objective pain measures such as VAS scores for significant periods of time. There are no objective measures of improvement of function. Therefore all criteria for the ongoing use of opioids have not been met and the request is not medically necessary.

**Tramadol 50mg, #60:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Medications for chronic pain.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids for chronic pain.

**Decision rationale:** The California chronic pain medical treatment guidelines section on opioids states for ongoing management: On-Going Management. Actions Should Include: (a) Prescriptions from a single practitioner taken as directed, and all prescriptions from a single pharmacy. (b) The lowest possible dose should be prescribed to improve pain and function. (c) Office: Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. Pain assessment should include: current pain; the least reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid; how long it takes for pain relief; and how long pain relief lasts. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. Information from family members or other caregivers should be considered in determining the patient's response to treatment. The 4 A's for Ongoing Monitoring: Four domains have been proposed as most relevant for ongoing monitoring of chronic pain patients on opioids: pain relief, side-effects, physical and psychosocial functioning, and the occurrence of any potentially aberrant (or non-adherent) drug-related behaviors. These domains have been summarized as the "4 A's" (analgesia, activities of daily living, adverse side effects, and aberrant drug taking behaviors). 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) (d) Home: To aid in pain and functioning assessment, the patient should be requested to keep a pain diary that includes entries such as pain triggers, and incidence of end-of-dose pain. It should be emphasized that using this diary will help in tailoring the opioid dose. This should not be a requirement for pain management. (e) Use of drug

screening or inpatient treatment with issues of abuse, addiction, or poor pain control. (f) Documentation of misuse of medications (doctor-shopping, uncontrolled drug escalation, drug diversion). (g) Continuing review of overall situation with regard to non-opioid means of pain control. (h) Consideration of a consultation with a multidisciplinary pain clinic if doses of opioids are required beyond what is usually required for the condition or pain does not improve on opioids in 3 months. Consider a psych consult if there is evidence of depression, anxiety or irritability. Consider an addiction medicine consult if there is evidence of substance misuse.

When to Continue Opioids: (a) If the patient has returned to work. (b) If the patient has improved functioning and pain. (Washington, 2002) (Colorado, 2002) (Ontario, 2000) (VA/DoD, 2003) (Maddox-AAPM/APS, 1997) (Wisconsin, 2004) (Warfield, 2004). The long-term use of this medication class is not recommended per the California MTUS unless there documented evidence of benefit with measurable outcome measures and improvement in function. There is no documented significant decrease in objective pain measures such as VAS scores for significant periods of time. There are no objective measures of improvement of function. Therefore, all criteria for the ongoing use of opioids have not been met and the request is not medically necessary.