

<b>Case Number:</b>	CM15-0178916		
<b>Date Assigned:</b>	09/21/2015	<b>Date of Injury:</b>	08/23/2001
<b>Decision Date:</b>	10/22/2015	<b>UR Denial Date:</b>	08/26/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/11/2015

### 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:

The injured worker is a 66 year old male who sustained an industrial injury on 08-23-2001. According to a progress report dated 08-18-2015, the injured worker continued to complain of neck and low back pain. He indicated that he had been having a lot more pain over the past couple of weeks, since he had not been able to get refills on his medications. The provider noted that Ultram and Norflex were effective. The medications helped with his pain and helped him functionally. Low back pain was problematic. Without the medications, pain was rated 8 to 9 on a scale of 1-10. With medications pain was rated 5. Without the medications he could only sit or stand for 30 minutes whereas with the medications he could sit for 1 ½ hours and stand for up to 1 hour. Without medications, he could walk for 2 blocks. With medications, he could walk for 4 blocks. Without the medications, he could only do yard work for about 15 minutes. With medications, he could do yard work for up to an hour. Without medications, he could only do dishes for maybe 10 minutes. With medications, he could do dishes for 30 minutes. He reported subjective and functional improvement with the medications. He did not abuse or share his medications. He did not use illicit drugs. He had a pain agreement on file. There was no aberrant behavior noted. Examination demonstrated tenderness to palpation along the cervical and lumbar paraspinal muscle bilaterally. Some trigger points were identified. His gait was mildly antalgic. Straight leg raise was negative but some back pain was reported. Neurologic exam was intact. Impression included cervical strain with myofascial pain with some generalized degenerative disc disease worse at C5-C6 level causing some disc desiccation and disc bulging along with facet degeneration, lumbar strain with myofascial pain and occasional complaints of radicular symptoms down the lower extremities, L5-S1 small disc protrusion along with

generalized degenerative changes locally, borderline narrowing of the neural foramen and traumatic brain injury and decrease in concentration along with vertigo and dizziness. The treatment plan included Ultram 50 mg #60 with 3 refills, Norflex 100 mg #60 with 3 refills, independent exercise program and a follow up in 4 months. Work status in the 08-18-2015 report was not indicated. An authorization request was submitted for review. The requested services included Ultram 50 mg every 8-12 hours as needed #60 with 3 refills and Norflex 100 mg every 12 hours as needed #60 with 3 refills. Documentation shows use of Norflex and Ultram dating back to 01-21-2014. Urine drug screens were not submitted for review. On 08-26-2015, Utilization Review non-certified the request for Norflex 100 mg #60 with 3 refills and modified the request for Ultram 50 mg #60 with 3 refills.

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

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

**Norflex 100mg #60 with 3 refills:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

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

**Decision rationale:** The California chronic pain medical treatment guidelines section on muscle relaxants states: Recommend non-sedating muscle relaxants with caution as a second-line option for short-term treatment of acute exacerbations in patients with chronic LBP. (Chou, 2007) (Mens, 2005) (Van Tulder, 1998) (Van Tulder, 2003) (Van Tulder, 2006) (Schnitzer, 2004) (See, 2008) Muscle relaxants may be effective in reducing pain and muscle tension, and increasing mobility. However, in most LBP cases, they show no benefit beyond NSAIDs in pain and overall improvement. Also there is no additional benefit shown in combination with NSAIDs. Efficacy appears to diminish over time, and prolonged use of some medications in this class may lead to dependence. (Homik, 2004) (Chou, 2004) This medication is not intended for long-term use per the California MTUS. The medication has not been prescribed for the flare-up of chronic low back pain but rather ongoing back and neck pain. This is not an approved use for the medication. For these reasons, criteria for the use of this medication have not been met. Therefore the request is not medically necessary.

**Ultram 50mg #60 with 3 refills:** Overturned

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**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 documented significant decrease in objective pain measures such as VAS scores for significant periods of time. With pain decreased from a 9/10 to a 5/10. There are objective measures of improvement of function or how the medication improves activities. Therefore all criteria for the ongoing use of opioids have been met and the request is medically necessary.