

<b>Case Number:</b>	CM15-0069003		
<b>Date Assigned:</b>	04/16/2015	<b>Date of Injury:</b>	09/07/2010
<b>Decision Date:</b>	05/20/2015	<b>UR Denial Date:</b>	03/11/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/10/2015

### 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 54 year old female who sustained an industrial injury on 9/7/10. The injured worker reported symptoms in the back. The injured worker was diagnosed as having lumbar radiculopathy, limb pain, low back syndrome, muscle spasms, lumbar region sprain, and lumbar vertebral compression fracture. Treatments to date have included lumbar epidural steroid injections, oral pain medication, topical patches, muscle relaxants, and a knee brace. Reports from September 2014 to February 2015 describe ongoing pain and muscle spasms. Medications have included norco, tramadol, and skelaxin since September 2014. Urine drug screens in July, August, and September 2014 were described as inconsistent, with positive tests for Demerol metabolites. A work status of modified with restrictions/temporarily totally disabled if restrictions not available was noted on 1/14/15. At a visit on 2/26/15, the injured worker complains of lower back pain with radiation to the lower extremities. The physician noted that the injured worker fell in January 2015 and fractured her left ankle, knee, and tailbone and has an anterior cruciate ligament tear. The physician noted that the cause of the fall was preexisting work related injury due to weakness to the left lower extremity. Medications as of February 2015 included lyrica, fentanyl patch, tegaderm patch, norco, tramadol, Lidoderm, and skelaxin. Medication regimen was noted to be effective, and that the injured worker was better able to accomplish activities of daily living with use of medication. Urine drug screens in October 2014 and January 2015 were noted to be consistent. The urine drug screen in January 2015 was collected on the date of an office visit. The plan of care was for medication prescriptions and a follow up appointment at a later date. On 3/11/15, Utilization Review non-certified requests for

Lidoderm patch 5% #30, and skelaxin 800 mg #90, and modified requests for norco 10/325 #60 to #30 and tramadol 50 mg #120 to #100. UR cited the MTUS.

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

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

**Norco 10/325mg, 1-2 tablets daily, #60:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 79-88, 91.

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

**Decision rationale:** This injured worker has been prescribed multiple opioid medications including norco since September 2014. There is insufficient evidence that the treating physician is prescribing opioids according to the MTUS, which recommends prescribing according to function, with specific functional goals, return to work, random drug testing, and opioid contract. Functional goals were not discussed, and it was not documented if the injured worker was currently working. The work status in January 2015 was noted to be modified work with restrictions and temporarily totally disabled if restrictions were not available. No opioid contract was submitted. Three urine drug screens were noted to be inconsistent with prescribed medications, with findings of demerol metabolites but no prescription for demerol. The records clearly indicate inconsistent urine drug test and the inconsistent results are not explained by treating provider, which would be necessary for continued usage. Risk of abuse was documented as high but urine drug screens were performed less than monthly and not all were random collections as recommended by the guidelines. Per the MTUS, opioids are minimally indicated, if at all, for chronic non-specific pain, osteoarthritis, mechanical and compressive etiologies, and chronic back pain. There is no evidence of significant pain relief or increased function from the opioids used to date; ongoing pain was noted. The MTUS states that a therapeutic trial of opioids should not be employed until the patient has failed a trial of non-opioid analgesics. There is no evidence that the treating physician has utilized a treatment plan NOT using opioids, and that the patient has failed a trial of non-opioid analgesics. Ongoing management should reflect four domains of monitoring, including analgesia, activities of daily living, adverse side effects, and aberrant drug-taking behaviors. The documentation does not reflect improvement in pain. Change in activities of daily living screening for aberrant drug-taking behaviors were not documented. The injured worker had a fall which resulted in fractures in January 2015, which the treating physician attributed to pre-existing work related injury; there was no documentation of consideration of contribution to the fall from use of multiple opioids including norco, tramadol, and fentanyl. As currently prescribed, norco does not meet the criteria for long term opioids as elaborated in the MTUS and is therefore not medically necessary.

**Tramadol 50mg, 1 tablet QID, #120:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Tramadol Page(s): 119.

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

**Decision rationale:** Tramadol is a centrally acting synthetic opioid analgesic which is not recommended as a first line oral analgesic. Multiple side effects have been reported including increased risk of seizure especially in patients taking selective serotonin reuptake inhibitors (SSRIs), tricyclic antidepressants (TCAs) and other opioids. It may also produce life-threatening serotonin syndrome. This injured worker has been prescribed multiple opioid medications including tramadol since September 2014. There is insufficient evidence that the treating physician is prescribing opioids according to the MTUS, which recommends prescribing according to function, with specific functional goals, return to work, random drug testing, and opioid contract. Functional goals were not discussed, and it was not documented if the injured worker was currently working. The work status in January 2015 was noted to be modified work with restrictions and temporarily totally disabled if restrictions were not available. No opioid contract was submitted. Three urine drug screens were noted to be inconsistent with prescribed medications, with findings of demerol metabolites but no prescription for demerol. The records clearly indicate inconsistent urine drug test and the inconsistent results are not explained by treating provider, which would be necessary for continued usage. Risk of abuse was documented as high but urine drug screens were performed less than monthly and not all were random collections as recommended by the guidelines. Per the MTUS, opioids are minimally indicated, if at all, for chronic non-specific pain, osteoarthritis, mechanical and compressive etiologies, and chronic back pain. There is no evidence of significant pain relief or increased function from the opioids used to date; ongoing pain was noted. The MTUS states that a therapeutic trial of opioids should not be employed until the patient has failed a trial of non-opioid analgesics. There is no evidence that the treating physician has utilized a treatment plan NOT using opioids, and that the patient has failed a trial of non-opioid analgesics. Ongoing management should reflect four domains of monitoring, including analgesia, activities of daily living, adverse side effects, and aberrant drug-taking behaviors. The documentation does not reflect improvement in pain. Change in activities of daily living screening for aberrant drug-taking behaviors were not documented. The injured worker had a fall which resulted in fractures in January 2015, which the treating physician attributed to pre-existing work related injury; there was no documentation of consideration of contribution to the fall from use of multiple opioids including norco, tramadol, and fentanyl. As currently prescribed, tramadol does not meet the criteria for long term opioids as elaborated in the MTUS and is therefore not medically necessary.

**Lidoderm Patches 5%, 1 patch daily, #30:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Lidocaine Page(s): 117-118.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines topical analgesics Page(s): 111-113.

**Decision rationale:** Topical lidocaine is recommended for localized peripheral pain after there has been evidence of a trial of first line therapy with tricyclic or serotonin/norepinephrine reuptake inhibitor antidepressants or an antiepileptic drug such as gabapentin or lyrica. Topical lidocaine in dermal patch form (Lidoderm) has been designated for orphan status by the FDA for neuropathic pain, and further research is needed to recommend this treatment for chronic neuropathic pain disorders other than post-herpetic neuralgia. There was no documentation of postherpetic neuralgia or neuropathic pain for this injured worker, and no documentation of trial and failure of antidepressant or antiepileptic medication. The site of application and directions for use were not specified. Due to lack of indication, the request for lidoderm patch is not medically necessary.

**Skelaxin 800mg, 1 tablet TID, #90: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants (for pain) Page(s): 67. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Chapter.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines muscle relaxants Page(s): 63-66.

**Decision rationale:** The MTUS for chronic pain does not recommend muscle relaxants for chronic pain. Non-sedating muscle relaxants are an option for short-term exacerbations of chronic low back pain/chronic musculoskeletal pain. Metaxalone (Skelaxin) is reported to be a relatively non-sedating muscle relaxant. It should be used with caution in patients with renal or hepatic impairment. The injured worker has chronic pain with no evidence of prescribing for flare-ups. The quantity prescribed implies long term use, not for a short period of use for acute pain. The injured worker has been prescribed skelaxin for at least 6 months. No reports show any specific and significant improvement in pain or function as a result of prescribing muscle relaxants. Return to work, improvement in activities of daily living, decrease in medication use, or decrease in frequency of office visits were all not documented. There was no documentation of evaluation for renal or hepatic impairment. Due to length of use in excess of the guidelines and lack of functional improvement, the request for skelaxin is not medically necessary.