

<b>Case Number:</b>	CM15-0079852		
<b>Date Assigned:</b>	04/30/2015	<b>Date of Injury:</b>	05/18/2000
<b>Decision Date:</b>	06/11/2015	<b>UR Denial Date:</b>	03/31/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/27/2015

### 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:

This 63-year-old male sustained an industrial injury to the neck and back on 5/18/00 due to a fall. Current diagnoses included disorder of back, thoracic spine spondylosis without myelopathy, lumbago, displacement of thoracic disc without myelopathy, thoracic spine or lumbar spine neuritis or radiculitis, displacement of lumbar disc without myelopathy, cervical spinal stenosis, cervical disc displacement and disc degeneration, and shoulder pain. Previous treatment and evaluation included magnetic resonance imaging, electromyography, cervical spine surgery, two low back surgeries and medications. Reports in 2014 and 2015 note ongoing pain treated with medication. Work status was noted as off work/temporarily totally disabled. Multiple progress notes document requests for physical therapy; however, there was no documentation of any completed physical therapy. Percocet, gabapentin, orphenadrine, and trazodone were prescribed since September 2014. Urine drug screens from 9/10/14, 12/15/14, and 2/4/15 were submitted. Progress note of 12/15 14 documents that there was no evidence of impairment, abuse, diversion, or hoarding of medication, and that urine drug tests were consistent with prescribed medication. A psychological evaluation on 2/3/15 noted that the injured worker has had problems sleeping for several years, with several awakenings at night and about five hours of sleep at night with use of trazodone. He reported chronic low back pain, cervical pain, and bilateral shoulder pain. In a pain management PR-2 dated 3/2/15, the injured worker complained of ongoing low back pain with worsening left lower extremity radicular pain. The injured worker complained of pain 7/10 on the visual analog scale without medications and 4-5/10 with medications. Medications were noted to assist with activities of daily living, mobility, and restorative sleep, with constipation as

the only reported side effect. No specific activities of daily living or results of any specific medication were discussed. A signed pain management agreement was discussed, and a copy of the agreement dated 1/7/15 was submitted. Urine drug tests were noted to be consistent. A urine drug screening was performed. Physical exam was remarkable for lumbar spine with painful and restricted range of motion, positive left straight leg raise, 5/5 lower extremity motor strength with the exception of left 4/5 strength at the extensor hallucis longus and dorsiflexion tibialis anterior and decreased sensation on the left L5 distribution. The treatment plan included medication refills (Orphenadrine, Trazadone, Percocet and Neurontin) and a urine drug screen. On 3/31/15, Utilization Review (UR) non-certified or modified requests for the items currently under Independent Medical Review, citing the MTUS.

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

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

**Orphenadrine Citrate ER 100mg #60 (retrospective dos:02/04/15): Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain) Page(s): 64-66.

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

**Decision rationale:** This injured worker has chronic neck and back pain. Orphenadrine has been prescribed for at least five months. 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. The muscle relaxant prescribed in this case is sedating. 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. No reports show any specific and significant improvement in pain or function because of prescribing muscle relaxants. Work status remains off work/temporarily very disabled. There was no documentation of decrease in medication use, improvement in specific activities of daily living, or decrease in frequency of office visits. Orphenadrine (Norflex) is similar to diphenhydramine, but with greater anticholinergic effects; the mode of action is not clearly understood and effects are thought to be secondary to analgesic and anticholinergic properties. Side effects include drowsiness, urinary retention, and dry mouth; it has been reported in case studies to be abused for euphoria and to have mood-elevating effects. Due to length of use in excess of the guidelines, and lack of functional improvement, the request for orphenadrine is not medically necessary.

**Trazadone 50mg #60 (retrospective dos: 02/04/15): Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressants for chronic pain Page(s): 13-16. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Chapter.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines antidepressants Page(s): 13-16. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) chronic pain chapter: insomnia treatment.

**Decision rationale:** This injured worker has chronic neck and back pain. Trazodone has been prescribed for at least five months. Trazodone is a tetracyclic antidepressant used to treat depression and anxiety disorders. Per the MTUS, antidepressants are recommended as a first line option for neuropathic pain, and as a possibility for non-neuropathic pain, unless they are poorly tolerated, contraindicated, or ineffective. Assessment of treatment efficacy should include not only pain outcomes, but also an evaluation of function, changes in use of other analgesic medication, sleep quality and duration, and psychological assessment. There was no documentation of functional improvement because of use of trazodone. Work status remains off work/temporarily very disabled. There was no documentation of decrease in medication use, improvement in specific activities of daily living, or decrease in frequency of office visits. In this case, the documentation suggests that trazodone was prescribed for sleep. Sedating antidepressants such as amitriptyline, trazodone, and mirtazapine have been used to treat insomnia; there is less evidence to support their use for insomnia but they may be an option in patients with coexisting depression. Trazodone is one of the most commonly prescribed agents for insomnia. Side effects of this drug include nausea, dry mouth, constipation, drowsiness, and headache. Negative next-day effects such as ease of awakening may offset improvements in sleep onset. Tolerance may develop and rebound insomnia has been found after discontinuation. The MTUS does not address the use of hypnotics other than benzodiazepines. No physician reports describe the specific criteria for a sleep disorder. Treatment of a sleep disorder, including prescribing hypnotics, should not be initiated without a careful diagnosis. There is no evidence of that in this case. For the treatment of insomnia, pharmacologic agents should only be used after careful evaluation of potential causes of sleep disturbance. Specific components of insomnia should be addressed. There was no documentation of evaluation of sleep disturbance in the injured worker, and components insomnia was not addressed. Due to lack of functional improvement, potential for tolerance and rebound insomnia, and insufficient evaluation of sleep disturbance, the request for trazodone is not medically necessary.

**Urine drug screen (retrospective dos: 03/03/15): Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Urine drug testing Page(s): 43.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines drug testing p. 43, opioids p. 77- 78, p. 89, p. 94 Page(s): 43, 77-78, 89, 94. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) chronic pain chapter: urine drug testing.

**Decision rationale:** This injured worker has chronic neck and back pain, with prescription of opioid medication (percocet) for at least five months. Per MTUS chronic pain medical treatment guidelines, urine drug screens are recommended as an option to assess for the use or the presence of illegal drugs, in accordance with a treatment plan for use of opioid medication, and as a part of a pain treatment agreement for opioids. Per the ODG, urine drug testing is recommended as a tool to monitor compliance with prescribed substances, identify use of undisclosed substances, and uncover diversion of prescribed substances. Urine drug testing is recommended at the onset of treatment when chronic opioid management is considered, if the patient is considered to be at risk on addiction screening, or if aberrant behavior or misuse is suspected or detected. Ongoing monitoring is recommended if a patient has evidence of high risk of addiction and with certain clinical circumstances. Frequency of urine drug testing should be

based on risk stratification. Patients with low risk of addiction/aberrant behavior should be tested within six months of initiation of therapy and on a yearly basis thereafter. Patients at moderate risk for addiction/ aberrant behavior should be tested 2-3 times per year. Patients at high risk of adverse outcomes may require testing as often as once a month. Random collection is recommended. Results of testing should be documented and addressed. In this case, there was no documentation of risk assessment for aberrant behavior, which would be necessary to determine the frequency of testing. One progress note states that there was no evidence of impairment, abuse, diversion, or hoarding of medication. Urine drug screens were described as consistent, and results of three tests performed from September 2014 to February 2014 were consistent with prescribed medications as documented. The frequency of testing performed is in excess of the guideline recommendations for testing at low risk of aberrant behavior; although a formal risk assessment was not documented, the submitted records suggest that this injured worker was at low risk of aberrant behavior. As this injured worker has already had two consistent urine drug screens within a four-month period, additional urine drug testing at the time of the request would only be indicated for individuals at moderate or high risk of aberrant behavior, which was not documented in this case. Due to lack of documentation of moderate or high risk of aberrant behavior, the request for Urine drug screen (retrospective dos: 03/03/15) is not medically necessary.

**Physical therapy 2-3 times/week for 4 weeks (retrospective dos: 02/04/15): Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical medicine Page(s): 98-99, 48.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines physical medicine Page(s): 98-99. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) pain chapter: physical medicine treatment.

**Decision rationale:** Physical medicine is recommended by the MTUS with a focus on active treatment modalities to restore flexibility, strength, endurance, function, and range of motion, and to alleviate discomfort. The ODG states that patients should be formally assessed after a six visit clinical trial to evaluate whether physical therapy has resulted in positive impact, no impact, or negative impact prior to continuing with or modifying the physical therapy. Both the MTUS and ODG note that the maximum number of sessions for unspecified myalgia and myositis is 9-10 visits over 8 weeks, and 8-10 visits over 4 weeks for neuralgia, neuritis, and radiculitis. In this case, no prior physical therapy was documented in the records submitted, and the request for physical therapy would be considered an initial request. The eight to twelve visits requested is in excess of the six visit clinical trial recommended by the guidelines. Due to number of sessions requested in excess of the guidelines, the request for Physical therapy 2-3 times/week for 4 weeks (retrospective dos:02/04/15) is not medically necessary.