

Case Number:	CM15-0129745		
Date Assigned:	08/11/2015	Date of Injury:	06/29/2005
Decision Date:	10/02/2015	UR Denial Date:	06/16/2015
Priority:	Standard	Application Received:	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: New York, California
 Certification(s)/Specialty: Emergency 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 59-year-old male who sustained an industrial injury on 06-29-2005 resulting in injury to the neck and low back after falling from a ladder. Treatment provided to date has included physical therapy; chiropractic treatments; lumbar epidural steroid injections without benefit; trigger point injections with minimal and temporary relief; medications; and conservative therapies and care. Recent diagnostic testing included: MRI of the lumbar spine (2015) showing heterogeneous marrow with patchy areas of infiltration into the vertebral bodies, multilevel discogenic disease, multilevel 4mm disc osteophyte complexes causing mild to moderate spinal canal narrowing, mild retrolisthesis, moderate bilateral neural foraminal narrowing, and a 17mm by 14mm TR hyper-intense lesion in the left paraspinal musculature; and random urine drug screenings (12-09-14, 02-10-15, 03-10-15, 04-07-2015 and 05-12-15) which have been consistent with prescribed medications. Comorbidities included high blood pressure. There were no other dates of injury noted. On 05/12/2015, physician progress report noted complaints of low back and bilateral hip pain. The pain was rated 6 out of 10 in severity without change from previous visit (04-07-2015). Pain was reported to radiate to the bilateral lower extremities and was associated with numbness and tingling. Additional complaints included difficulty falling and staying asleep secondary to muscle spasms, and anxiety and depression. Current medications include OxyContin, Soma, transdermal Fentanyl, Neurontin, Nortriptyline, and trazodone. The injured worker reported that he was taking his medications accordingly and that they were helpful in controlling pain. The physical exam revealed an antalgic gait to the left; unable to perform heel-to-toe walk; abnormal lordosis; guarding, spasms and tenderness upon palpation of the lumbar paravertebral musculature; moderate

to severe L4- S1 facet tenderness; positive Kemp's test bilaterally; positive straight leg raises bilaterally in both the seated and supine positions; positive sacroiliac tenderness bilaterally, positive Faber's and Patrick test bilaterally; positive sacroiliac thrust test; positive Yeoman's test bilaterally; restricted range of motion in the lumbar spine; decreased sensation in the L4-S1 dermatomes bilaterally; decreased motor strength in the bilateral big toe extensors, knee extensors and hip flexors; and decreased deep tendon reflexes in the bilateral lower extremities. The provider noted diagnoses of lumbar disc disease, lumbar radiculopathy, lumbar facet syndrome, cervical spine 4 level fusion (non-industrial). Plan of care includes bilateral L3-4 and L4-5 transforaminal epidural steroid injections, continuation of current medications (OxyContin, Soma, transdermal Fentanyl, Neurontin, Nortriptyline and trazodone), continued home exercises, random urine drug screening, and follow-up in 6 weeks. The injured worker's work status remained temporarily very disabled. It was also reported in the clinical notes that the injured worker was taking Flexeril, which was not prescribed by the treating physician. It was also reported that the injured worker's Morphine equivalent value is greater than 80mg per day. Additionally, the treating physician noted that the injured worker scored higher than 19 on the opioid risk assessment and SOAPP-R, which indicates that the injured worker is at high risk for narcotic abuse, misuse and dependency. The request for authorization and IMR (independent medical review) includes: OxyContin 30mg #120, Soma 350mg #60, Nortriptyline 75mg #60, and a retrospective request for a urine drug screening with a date of service: 05-12-2015.

IMR ISSUES, DECISIONS AND RATIONALES

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

Oxycontin 30mg, #120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Oxycodone; Opioids, specific drug list - Oxycodone immediate release, Oxycodone/acetaminophen; Weaning of Medications Page(s): 97, 92, 124.

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

Decision rationale: CA MTUS Definitions identify that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. OxyContin is the brand name of a time-release formula of the analgesic chemical oxycodone, which is also an opioid. Opioid drugs are available in various dosage forms and strengths. They are considered the most powerful class of analgesics that may be used to manage chronic pain. MTUS discourages long-term usage of opioids unless there is evidence of "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. The MTUS also states that the total daily dose of opioid should not exceed 120 mg oral morphine equivalents. "Rarely, and only after pain management consultation, should the total daily dose of opioid be increased above 120 mg oral morphine equivalents." The MTUS also recommends the discontinuation of opioids when there is no overall improvement in function, unless there are extenuating circumstances. Weaning should occur under direct ongoing medical supervision as a slow taper except for the below mentioned possible indications for immediate discontinuation. In addition, the MTUS

recommends that prescriptions be prescribed from a single practitioner and taken as directed, and all prescriptions from a single pharmacy. Upon review of the clinical documentation, the treating physician does not document: 1) the least reported pain over the period since last assessment; 2) average pain; 3) intensity of pain after taking the opioid; 4) how long it takes for pain relief; 5) how long pain relief lasts; 6) improvement in pain; or 7) improvement in function. In addition, there has been no overall measurable improvement in function or decrease in pain while taking this medication over the last several months. Furthermore, the injured worker has been prescribed opioid medications that may exceed the 120mg oral morphine equivalents. Urine drug screens have not been consistent with prescribed medications. The provider has not been prescribing within the recommendations of CA MTUS guidelines. As such, OxyContin 30mg #120 is not medically necessary.

Soma 350mg, #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Carisoprodol (Soma, Soprodal 350, Vanadom, generic available).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Carisoprodol (Soma) & Muscle relaxants (for pain) Page(s): 29 & 63-66.

Decision rationale: CA MTUS-Definitions identify that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. Carisoprodol (Soma) is a centrally acting skeletal muscle relaxant whose primary active metabolite is meprobamate (a schedule-IV controlled substance). According to the MTUS, Soma (carisoprodol) is not recommended and is not indicated for long-term use (more than 2-3 weeks). The MTUS recommends non-sedating muscle relaxants with caution as a second-line option for short-term treatment of acute exacerbations in patients with chronic LBP (low back pain) as they can reduce pain from muscle tension and possibly increase mobility. However, in most cases involving LBP, they provide no more benefit beyond NSAIDs in pain and overall improvement. Skeletal muscle relaxants should not be the primary drug class of choice for musculoskeletal conditions. Efficacy appears to diminish over time, and prolonged use of some medications in this class may lead to dependence. In this case, clinical notes show that the injured worker has been prescribed Soma for several months with insufficient evidence of reduction in pain, reduction in muscle spasms, and/or improvement in function. Additionally, the injured worker was noted to be taking Flexeril, which is also a centrally acting skeletal muscle relaxant, which was prescribed by a different physician. Furthermore, the MTUS does not recommend or support the long-term use of Soma for more than 2-3 weeks. Therefore, Soma 350mg #60 is not medically necessary.

Nortriptyline 75mg, #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressants for chronic pain.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressants for chronic pain Page(s): 13-16.

Decision rationale: CA MTUS-Definitions identify that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work

restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. Nortriptyline is a tricyclic antidepressant used for treating depression. According to the MTUS guidelines, tricyclic antidepressants considered a first-line agent unless they are ineffective, poorly tolerated, or contraindicated. Analgesic effects usually occur within a few days to a week, while antidepressant effects can take longer to yield results. "Long-term effectiveness of these medications has not been established". "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". The MTUS also states that tricyclic antidepressants are recommended as a first-line option for neuropathic pain, especially if pain is accompanied by insomnia, anxiety, or depression. However, "Caution is required because tricyclic agents have a low threshold for toxicity, and tricyclic antidepressant overdose is a significant cause of fatal drug poisoning due to their cardiovascular and neurological effects. These agents are contraindicated in patients with cardiac conduction disturbances and/or decompensation (they can produce heart block and arrhythmias)". In this case, the injured worker exhibits evidence of neuropathic pain and was reported to have sleep deficits and issues, in addition to anxiety and depression. However, the injured worker has been prescribed this medication for several months with insufficient evidence of reduced pain, functional improvement or improvement in quality of life with the use of this medication. The IW reports ongoing pain without reduction. The IW remains out of work. As such, the requested Nortriptyline 75mg #60 is not medically necessary.

Retrospective urine drug screen (DOS: 05/12/2015): Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, steps to avoid misuse/addiction.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Drug testing & Criteria for use of Opioids Page(s): 43 & 74-96.

Decision rationale: According to the MTUS guidelines, urine drug testing (UDT) can be used to assess for misuse of prescribed medications, and the presence of non-prescribed or illegal drugs. There are two different types of UDT: 1) Screening Assays, and 2) Confirmatory testing. Per the ODG, "screening assays are based on immunoassays, which can be either laboratory-based or point-of-collection testing (POC). POC testing is also commonly referred to as "dip-stick" testing. This latter type of testing is performed on-site and usually requires no instrumentation." Confirmatory testing is laboratory based testing which can identify and quantify specific drugs. The MTUS and ODG do not specify the recommended frequency of urine drug testing. However, the ODG states that the "When the POC screen is appropriate for the prescribed drugs without evidence of non-prescribed substances, confirmation is generally not required. Confirmation should be sought for (1) all sample testing negative for prescribed drugs, (2) all samples positive for non-prescribed opioids, and (3) all samples positive for illicit drugs". Additionally, the ODG recommends UDT: 1) at the onset of treatment of a new patient who is already using opioids; 2) in cases where a patient ask for a specific drug, refuses generic forms, or refuses changes in scheduled drugs or other treatments; 3) if the patient has a positive "at risk" screening on file; or 4) if aberrant behavior or misuse is suspected or detected. In this case, the injured worker has had previous and recent urine drug screenings that were inconsistent with prescribed therapy noting other medications not prescribed by the same physician. Additionally, the injured worker was noted to be at high risk for dependency, abuse and or misuse due to high scores on the opioid risk assessment and SOAPP-R. Furthermore, at the

time of the test, the injured worker was being prescribed multiple high dose opioid medications. It should be noted that the urine drug screens have not been random as they have occurred at scheduled appointment. Nonetheless, the urine drug screening was medically necessary on 05-12-2015.