

Case Number:	CM13-0035241		
Date Assigned:	12/13/2013	Date of Injury:	05/03/2012
Decision Date:	02/10/2014	UR Denial Date:	09/20/2013
Priority:	Standard	Application Received:	10/17/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Occupational Medicine and is licensed to practice in Mississippi and California. 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 physician 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 claimant is a 38 year old female with date of injury of 5/3/2012. Diagnoses include 1) sprain of neck 2) sprain thoracic region 3) rheumatoid arthritis 4) sprain lumbosacral 5) cervicalgia 6) depression 7) organic brain syndrome NOS and 8) psychological factors affecting a general medical condition. Clinical documentation indicates that the claimant has intermittent neck, low back, and lower extremity pain. There is tenderness in the cervical and lumbar areas of the spine. Left foot exam reveals tenderness. A supplemental report dated 10/17/2013 requesting reconsideration of the request for hydrocodone and cyclobenzaprine states that cyclobenzaprine is only used for muscle spasms, and that the claimant has ongoing pain and spasms from her neck and back. The only benefit she is receiving from her medications is temporary relief. Pain management note dated 6/14/2013 indicates that pain medication treatment included hydrocodone 5/500 mg twice daily as needed, cyclobenzaprine 7.5 mg twice daily as needed, and diclofenac XR 100 mg daily.

IMR ISSUES, DECISIONS AND RATIONALES

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

Hydrocodone 10/325mg #60: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids for Chronic Pain Page(s): 78 & 80.

Decision rationale: Per the Chronic Pain Medical Treatment Guidelines MTUS (Effective July 18, 2009) 8 C.C.R. §§9792.20 - 9792.26, opioids used for chronic back pain "appears to be efficacious but limited for short-term pain relief, and long-term efficacy is unclear (>16 weeks), but also appears limited. Failure to respond to a time limited course of opioids has led to the suggestion of re-assessment and consideration of alternative therapy. There is no evidence to recommend one opioid over another. In patients taking opioids for back pain, the prevalence of lifetime substance use disorders has ranged from 36% to 56% (a statistic limited by poor study design). Limited information indicated that up to one-fourth of patients who receive opioids exhibit aberrant medication-taking behavior. (Martell-Annals, 2007) (Chou, 2007) There are three studies comparing Tramadol to placebo that have reported pain relief, but this increase did not necessarily improve function. (Deshpande, 2007)" Per the Chronic Pain Medical Treatment Guidelines MTUS (Effective July 18, 2009) 8 C.C.R. §§9792.20 - 9792.26, opioid on-going management 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 nonadherent) 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 po

Cyclobenzaprine 7.5mg #60: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Cyclobenzaprine, Muscle Relaxant Page(s): 41 & 42, 63.

Decision rationale: Per the Chronic Pain Medical Treatment Guidelines MTUS (Effective July 18, 2009) 8 C.C.R. §§9792.20 - 9792.26, cyclobenzaprine is "recommended as an option, using a short course of therapy. See Medications for chronic pain for other preferred options. Cyclobenzaprine (Flexeril®) is more effective than placebo in the management of back pain; the effect is modest and comes at the price of greater adverse effects. The effect is greatest in the first 4 days of treatment, suggesting that shorter courses may be better. (Browning, 2001) Treatment should be brief. There is also a post-op use. The addition of cyclobenzaprine to other agents is not recommended. (Clinical Pharmacology, 2008) Cyclobenzaprine-treated patients with fibromyalgia were 3 times as likely to report overall improvement and to report moderate reductions in individual symptoms, particularly sleep. (Tofferi, 2004) Note: Cyclobenzaprine is closely related to the tricyclic antidepressants, e.g., amitriptyline. See Antidepressants. Cyclobenzaprine is associated with a number needed to treat of 3 at 2 weeks for symptom improvement in LBP and is associated with drowsiness and dizziness. (Kinkade, 2007) Cyclobenzaprine is a skeletal muscle relaxant and a central nervous system (CNS) depressant that is marketed as Flexeril by Ortho McNeil Pharmaceutical." Per the Chronic Pain Medical Treatment Guidelines MTUS (Effective July 18, 2009) 8 C.C.R. §§9792.20 - 9792.26, muscle relaxants are "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) Sedation is the most commonly reported adverse effect of muscle relaxant medications. These drugs should be used with caution in patients driving motor vehicles or operating heavy machinery. Drugs with the most limited published evidence in terms of clinical effectiveness include chlorzoxazone, methocarbamol, dantrolene, and baclofen. (Chou, 2004) According to a recent review in American Family Physician, skeletal muscle relaxants are the most widely prescribed drug class for musculoskeletal conditions (18.5% of prescriptions), and the most commonly prescribed antispasmodic agents are carisoprodol, cyclobenzaprine, metaxalone, and methocarbamol, but despite their popularity, skeletal muscle relaxants should not be the primary drug class of choice for musculoskeletal conditions. (See2, 2008)" These quoted guidelines do not support the use of muscle relaxan