

Case Number:	CM13-0039097		
Date Assigned:	03/21/2014	Date of Injury:	02/14/2001
Decision Date:	04/23/2014	UR Denial Date:	09/25/2013
Priority:	Standard	Application Received:	10/03/2013

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. The expert reviewer is Board Certified in Emergency Medicine, and is licensed to practice in New York. 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/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 patient is a 63-year-old female who was injured on February 14, 2001, when heavy equipment fell on her. The patient continued to experience lower back pain, which radiated to the left thigh. Physical examination was notable for tenderness with range of motion of the cervical spine and lumbar spine. Diagnoses included low back pain and cervical vertebral fusion. Treatment included surgery, and prescriptions. Requests for authorization for Ibuprofen 800 mg # 90, Hydrocodone 10/325 # 90, Diazepam 10 mg, #120, and Effexor ER 75 mg # 60 were submitted for consideration.

IMR ISSUES, DECISIONS AND RATIONALES

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

PRESCRIPTION FOR IBUPROFEN 800MG #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines MTUS CHRONIC PAIN GUIDELINES, NSAIDS, SPECIFIC DRUG LIST & ADVERSE.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines MTUS CHRONIC PAIN MEDICAL TREATMENT GUIDELINES. Page(s): 67-68.

Decision rationale: Ibuprofen is a nonsteroidal anti-inflammatory drug. Chronic Medical Treatment Guidelines state that "anti-inflammatory drugs are the traditional first line of treatment, but long term use may not be warranted". For osteoarthritis it was recommended that

the lowest dose for the shortest length of time be used. It was not shown to be more effective than acetaminophen, and had more adverse side effects. Adverse effects for GI toxicity and renal function have been reported. Medications for chronic pain usually provide temporary relief. Medications should be prescribed only one at a time and should show effect within 1-3 days. Record of pain and function with the medication should be recorded. In this case documentation indicates that the patient is still experiencing 10/10 pain and is, therefore, ineffective. Duration of use is not clear, but long term use of the medication is implied by the number of pills prescribed. The risk of adverse effects increases with duration. Effectiveness of the medication has not been established. The request should not be authorized.

PRESCRIPTION FOR HYDROCODONE-ACETAMINOPHEN 10/325MG #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines MTUS CHRONIC PAIN GUIDELINES, OPIOIDS, CRITERIA FOR USE..

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines MTUS CHRONIC PAIN MEDICAL TREATMENT GUIDELINES. Page(s): 74-96.

Decision rationale: Hydrocone is an opioid medication. Chronic Pain Medical Treatment Guidelines state that opioids are not recommended as a first line therapy. Opioid should be part of a treatment plan specific for the patient and should follow criteria for use. Criteria for use include establishment of a treatment plan, determination if pain is nociceptive or neuropathic, failure of pain relief with non-opioid analgesics, setting of specific functional goals, and opioid contract with agreement for random drug testing. If analgesia is not obtained, opioids should be discontinued. The patient should be screened for likelihood that he or she could be weaned from the opioids if there is no improvement in pain of function. It is recommended for short term use if first-line options, such as acetaminophen or NSAIDS have failed. In this case the medication was not prescribed for short term use and the criteria for opioid use were not met. Duration of use is not clear, but long term use of the medication is implied by the number of pills prescribed. The documentation in the medical record states that the patient is still experiencing 10/10 pain. Analgesia has not been obtained and the request should not be authorized.

PRESCRIPTION FOR DIAZEPAM 10MG #120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines MTUS CHRONIC PAIN GUIDELINES, BENZODIAZEPINES..

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines MTUS CHRONIC PAIN MEDICAL TREATMENT GUIDELINES. Page(s): 23.

Decision rationale: Valium is a benzodiazepine medication. Benzodiazepines are not recommended for long-term use because long-term efficacy is unproven and there is a risk of dependence. Benzodiazepines are a major cause of overdose, particularly as they act synergistically with other drugs such as opioids (mixed overdoses are often a cause of fatalities). Their range of action includes sedative/hypnotic, anxiolytic, anticonvulsant, and muscle relaxant. Chronic benzodiazepines are the treatment of choice in very few conditions. Tolerance to

hypnotic effects develops rapidly. Tolerance to anxiolytic effects occurs within months and long-term use may actually increase anxiety. Tolerance to lethal effects does not occur and a maintenance dose may approach a lethal dose as the therapeutic index increases. In this case duration of use is not clear, but long term use of the medication is implied by the number of pills prescribed. In addition the medication is not effective as the patient continues to experience 10/10 pain. The request should not be authorized.

PRESCRIPTION FOR EFFEXOR EXTENDED RELEASE 75MG #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines MTUS CHRONIC PAIN GUIDELINES, EFFEXOR, VENLAFAXINE (EFFEXOR) AND A.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines MTUS CHRONIC PAIN MEDICAL TREATMENT GUIDELINES. Page(s): 13-16.

Decision rationale: Effexor is an antidepressant, specifically a selective serotonin and norepinephrine reuptake inhibitor. Antidepressants are recommended as a first line option for neuropathic pain, and as a possibility for non-neuropathic pain. Tricyclics are generally considered a first-line agent unless they are ineffective, poorly tolerated, or contraindicated. Analgesia generally occurs within a few days to a week, whereas antidepressant effect takes longer to occur. 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. Effexor is FDA approved for the treatment of anxiety, depression, panic disorder and social phobias. It is used off-label for fibromyalgia, neuropathic pain, and diabetic neuropathy. In this case duration of use is not clear, but long term use of the medication is implied by the number of pills prescribed. The patient continues to experience 10/10 pain. The medication has not been effective in management of pain. The request should not be authorized.