

Case Number:	CM14-0003340		
Date Assigned:	01/31/2014	Date of Injury:	06/16/2013
Decision Date:	06/30/2014	UR Denial Date:	12/18/2013
Priority:	Standard	Application Received:	01/08/2014

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 Occupational Medicine and is licensed to practice in 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 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 was injured on 06/16/13. His medications naproxen, cyclobenzaprine, omeprazole, and Tramadol are under review. He had an MRI of the lumbar spine on 07/19/13 that showed an L5-S1 small central disc protrusion without significant stenosis or neural impingement. He received naproxen, cyclobenzaprine, ondansetron, omeprazole, quazepam, and Tramadol on 09/04/13. He saw [REDACTED] on 11/07/13 and complained of persistent low back pain that radiated to the right lower extremity with numbness and tingling. He had tenderness limited to the distal lumbar segments and pain with terminal motion. Seated nerve root test was positive and there was dysesthesias at the right L5 and S1 dermatomes. He received injections of Toradol and vitamin B12. He had electrodiagnostic studies on 11/08/13 that were negative for radiculopathy. On 12/03/13, he complained of constant and severe pain in the low back radiating to the right lower extremity with numbness and tingling. He was waiting to see a pain management physician for a lumbar epidural steroid injection. He had tenderness and pain with terminal motion with positive seated nerve root test. Dysesthesias were present. Medications were recommended. On 12/05/13, he was prescribed cyclobenzaprine, omeprazole, Tramadol, and naproxen. He saw the physician for a pain management consultation on 12/10/13 and was diagnosed with radiculopathy. He had a positive straight leg raise test on the right side. He had failed conservative treatments. These medications were not medically necessary on 12/18/13 because additional information was needed to approve the medications.

IMR ISSUES, DECISIONS AND RATIONALES

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

NAPROXEN SODIUM 550MG, #100: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): 60-61, 67-73.

Decision rationale: The history and documentation do not objectively support the request for continued use of naproxen for the claimant's ongoing pain. The CA MTUS p. 102 state re: NSAIDs for back pain - acute exacerbations of chronic pain: Recommended as a second-line treatment after acetaminophen. Neuropathic pain: There is inconsistent evidence for the use of these medications to treat long-term neuropathic pain, but they may be useful to treat breakthrough and mixed pain conditions such as osteoarthritis (and other nociceptive pain) in with neuropathic pain." Also, "before prescribing any medication for pain, the following should occur: (1) determine the aim of use of the medication; (2) determine the potential benefits and adverse effects; (3) determine the patient's preference. Only one medication to be given at a time, and interventions that are active and passive should remain unchanged at the time of the medication change. A trial should be given for each individual medication. Analgesic medication should show effects within 1 to 3 days, and the analgesic effect of antidepressants should occur within one week. A record of pain and function with the medication should be recorded. (Mens 2005)" In this case, there is no evidence of the presence of osteoarthritis to support the continued use of an anti-inflammatory medication of this type and also no documentation of a trial and failure of use of acetaminophen. The medical necessity of the ongoing use of naproxen has not been demonstrated.

CYCLOBENZAPRINE HYDROCHLORIDE 7.5MG, #120: Upheld

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

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

Decision rationale: The history and documentation do not objectively support the request for the continued use of cyclobenzaprine. The MTUS Chronic Pain Medical Treatment guidelines state for cyclobenzaprine (Flexeril), "Recommended as an option, using a short course of therapy. The effect is greatest in the first four days of treatment, suggesting that shorter courses may be better. (Browning, 2001). Treatment should be brief." Additionally, MTUS and ODG state "relief of pain with the use of medications is generally temporary and measures of the lasting benefit from this modality should include evaluating the effect of pain relief in relationship to improvements in function and increased activity. Before prescribing any medication for pain, the following should occur: (1) determine the aim of use of the medication; (2) determine the potential benefits and adverse effects; (3) determine the patient's preference. Only one medication to be given at a time, and interventions that are active and passive should remain unchanged at the time of the medication change. A trial should be given for each individual medication. Analgesic medication

should show effects within 1 to 3 days, a record of pain and function with the medication should be recorded. (Mens 2005) Up-to-date for "Flexeril" also recommends "do not use longer than 2-3 weeks" and is for "short-term (2-3 weeks) use for muscle spasm associated with acute painful musculoskeletal conditions." The medical documentation provided does not establish the need for long-term/chronic usage of Flexeril, which MTUS guidelines advise against. Additionally, the medical records provided do not provide objective findings of acute spasms or a diagnosis of acute spasm. In this case, the claimant's pattern of use of medications, including other first-line drugs such as acetaminophen and anti-inflammatory and the response to them, including relief of symptoms and documentation of functional improvement, have not been described. As such, this request for cyclobenzaprine hydrochloride 7.5 mg #120 is not medically necessary.

OMEPRAZOLE DR 20MG, #120: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Proton pump inhibitors Page(s): 68-69.

Decision rationale: The history and documentation do not objectively support the request for continued use of omeprazole. The MTUS state on p. 102 re: PPIs, "NSAIDs, GI symptoms & cardiovascular risk Patients at intermediate risk for gastrointestinal events and no cardiovascular disease:(1) a non-selective NSAID with either a PPI (Proton Pump Inhibitor, for example, 20 mg omeprazole daily) or misoprostol (200 µg four times daily) or (2) a Cox-2 selective agent. Long-term PPI use (> 1 year) has been shown to increase the risk of hip fracture (adjusted odds ratio 1.44). Patients at high risk for gastrointestinal events with no cardiovascular disease: A Cox-2 selective agent plus a PPI if absolutely necessary. Patients at high risk of gastrointestinal events with cardiovascular disease: If GI risk is high the suggestion is for a low-dose Cox-2 plus low dose Aspirin (for cardio protection) and a PPI. If cardiovascular risk is greater than GI risk the suggestion is naproxen plus low-dose aspirin plus a PPI. (Laine, 2006) (Scholmerich, 2006) (Nielsen, 2006) (Chan, 2004) (Gold, 2007) (Laine, 2007)" In this case, there is no documented evidence of gastrointestinal risk factors, including a history of gastrointestinal disease or current symptoms to support the continued use of this type of medication. The medical necessity of its use has not been clearly demonstrated.

TRAMADOL HYDROCHLORIDE ER 150MG, #90: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines tramadol Page(s): 113, 82-83.

Decision rationale: The history and documentation do not objectively support the request for ongoing use of Tramadol. The CA MTUS p. 145 "Tramadol (Ultram®) is a centrally acting synthetic opioid analgesic and it is not recommended as a first-line oral analgesic." Page 114

further states "Opioid analgesics and Tramadol have been suggested as a second-line treatment (alone or in combination with first-line drugs). A recent consensus guideline stated that opioids could be considered first-line therapy for the following circumstances: (1) prompt pain relief while titrating a first-line drug; (2) treatment of episodic exacerbations of severe pain; [&] (3) treatment of neuropathic cancer pain. (Dworkin, 2007) Response of neuropathic pain to drugs may differ according to the etiology of therapeutic pain. There is limited assessment of effectiveness of opioids for neuropathic pain, with short-term studies showing contradictory results and intermediate studies (8-70 days) demonstrating efficacy. There is no documentation of trials and failure of or intolerance to other more commonly used first line drugs and no evidence that this medication was prescribed while a first line drug was being titrated to pain relief. The anticipated benefit or indications for the continued use of this medication have not been stated. The medical necessity of Tramadol has not been clearly demonstrated.