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| Case Number: | CM14-0011054 | | |
| Date Assigned: | 02/21/2014 | Date of Injury: | 08/10/2010 |
| Decision Date: | 08/04/2014 | UR Denial Date: | 12/26/2013 |
| Priority: | Standard | Application Received: | 01/27/2014 |

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 is a 38-year-old male who has submitted a claim for lumbar strain/sprain, facet syndrome, discogenic pain, chronic pain syndrome, sacroiliitis, piriformis syndrome and trochanteric bursitis, associated with an industrial injury date of August 10, 2010. Medical records from 2013 through 2014 were reviewed, which showed that the patient complained of persistent low back pain and bilateral knee pain. Physical examination revealed limited lumbar flexion and extension with pain felt centrally and to the left. There was tenderness over the left lower back, more so than the right, with spasm overlying the facet joints. Straight leg raise test was positive on the left. Gait was antalgic. Treatment to date has included physical therapy, transforaminal epidural injections, medications, which include Hydrocodone 2.5/325mg, Cyclobenzaprine 7.5mg, Nabumetone 750mg, Buspirone 10mg, Citalopram 20mg, Remeron 15mg, and Topamax 50mg. Utilization review from December 26, 2013 denied the requests for Hydrocodone 2.5/325mg QTY: 60, Cyclobenzaprine 7.5mg QTY: 90 and Ibuprofen 800mg QTY: 360. Hydrocodone was denied because long-term daily use of opioids is not supported and should not be continued if there is no evidence of significant functional and pain improvement. Reports noted continued severe pain at 10/10 and there was no discussion of any functional improvement. Cyclobenzaprine was denied because MTUS does not support long-term daily use and the report submitted did not show any significant pain or functional improvement with its use. Ibuprofen was denied because chronic NSAIDs have been provided and Relafen, which usually has less GI side effects than most NSAIDs, is causing GI side effects and not providing any benefit.

IMR ISSUES, DECISIONS AND RATIONALES

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

HYDROCODONE 2.5/325 MG QTY: 60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Hydrocodone, Opioids Page(s): 51, 74-96.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, On- Going Management, Page(s): 78-81.

Decision rationale: According to pages 78-81 of the CA MTUS Chronic Pain Medical Treatment Guidelines, ongoing opioid treatment is not supported unless prescribed at the lowest possible dose and unless there is ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. The monitoring of these outcomes over time should affect therapeutic decision and provide a framework for documentation of the clinical use of these controlled drugs. In this case, the patient has been on Norco 2.5/325mg tablet since 10/14/13. Specific measures of analgesia and functional improvements, such as improvements in activities of daily living were not documented. Also, guidelines suggest discontinuation of opioids if there is no overall improvement in function, and such is the case of the patient as recent progress reports state that the patient still complained of continued pain graded 8-9/10 even with medication use. Additional information is needed as guidelines require clear and concise documentation for ongoing management. Therefore, the request for HYDROCODONE 2.5/325 MG QTY: 60 is not medically necessary.

CYCLOBENZAPRINE 7.5 MG QTY: 90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Cyclobenzaprine (Flexeril) Page(s): 41,64.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines : Muscle relaxants Page(s): 41-42, 63-66.

Decision rationale: Cyclobenzaprine is a skeletal muscle relaxant and a central nervous system depressant with similar effects to tricyclic antidepressants. According to pages 41-42 of the CA MTUS Chronic Pain Medical Treatment Guidelines, sedating muscle relaxants are recommended with caution as a second-line option for short-term treatment of acute exacerbations in patients with chronic low back pain (LBP). However, in most LBP cases, they show no benefit beyond NSAIDs in pain and overall improvement. In addition, efficacy appears to diminish over time and prolonged use of some medications in this class may lead to dependence. The effect is modest and comes at the price of greater adverse effects. In this case, the patient has been on Cyclobenzaprine since 10/14/13. The recent clinical evaluation does not indicate significant relief of pain and functional improvement from cyclobenzaprine use. Furthermore, guidelines do not support chronic use of this medication. Therefore, the request for CYCLOBENZAPRINE 7.5 MG QTY: 90 is not medically necessary.

START IBUPROFEN 800 MG #60 X5 REFILLS QTY: 360: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Ibuprofen, (Motrin, Advil) Page(s): 51, 72.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS Page(s): 22, 46 AND 72.

Decision rationale: As stated on pages 22 and 46 of CA MTUS Chronic Pain Medical Treatment Guidelines, NSAIDs are recommended at the lowest dose for the shortest period in patients with moderate to severe pain and that there is no evidence of long-term effectiveness for pain or function. Long-term use of NSAIDs is not warranted. Page 72 of CA MTUS Chronic Pain Medical Treatment Guidelines state that ibuprofen can be taken for mild to moderate pain as 400 mg PO every 4-6 hours as needed. Doses greater than 400 mg have not provided greater relief of pain. In this case, patient has been on Ibuprofen since 10/29/13. Ibuprofen was discontinued and Nabumetone was started however Nabumetone caused heartburn and nausea which is why the physician wanted to start Ibuprofen again to see if it would work better than the other NSAIDs. Chronic NSAID intake however is not recommended by guidelines. Medical records submitted for review failed to show objective evidence of functional improvement derived from NSAID use. Therefore, the request for IBUPROFEN 800 MG #60 X5 REFILLS QTY: 360 is not medically necessary.