

Case Number:	CM14-0030747		
Date Assigned:	06/20/2014	Date of Injury:	02/03/2005
Decision Date:	10/31/2014	UR Denial Date:	02/10/2014
Priority:	Standard	Application Received:	02/20/2014

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 Physical Medicine and Rehabilitation 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 records presented for review indicate that this 50 year old female was reportedly injured on February 3, 2005. The mechanism of injury is noted as a repetitive overuse type event. The most recent progress note, dated January 6, 2014, indicates that there are ongoing complaints of right upper extremity pain that travels to the right lower extremity, headaches, and difficulty sleeping, numbness and tingling of the right hand, as well a weakness. The physical examination demonstrated a range of motion of the shoulder in flexion and abduction is 80 degrees, general tenderness to the upper extremities, range of motion of the wrist decreased range of motion of the bilateral shoulders, a decreased range of motion the elbow is 0 to 130 degrees with tenderness, range of motion of the wrist in flexion and extension is 50 degrees with tenderness and effusion is 50 degrees with tenderness and effusion, and a decrease in sensation to the right hand is reported. Diagnostic imaging studies were not presented. Previous treatment includes multiple medications, physical therapy, and pain management interventions. A request was made for Doral 15 milligrams quantity thirty, Voltaren XR 100 milligrams quantity sixty, Norco 10/325 milligrams quantity sixty, Fioricet (Butalbital/Acetaminophen) quantity sixty, and Fexmid 7.5 milligrams quantity sixty and was not certified in the preauthorization process on February 10, 2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Doral 15 mg, # 30: 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 Page(s): 24. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain

Decision rationale: Per CA MTUS guidelines, Benzodiazepines are not recommended for long-term use. Doral (Quazepam) is a benzodiazepine sleep hypnotic, which is used for short-term (usually two to six weeks) treatment of insomnia. Proper sleep hygiene is critical to the individual with chronic pain, which has not been addressed in this injured worker. Furthermore, there is no documentation of a detailed assessment of insomnia. Additionally, it is unclear from the records for how long the injured worker has been prescribed this medication since guidelines only recommend short-term use for 2-6 weeks. Nonetheless, there is no documentation of any significant improvement in sleep with prior use. Thus, the request is not medically necessary.

Voltaren XR 100 mg, # 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 Page(s): 67-73.

Decision rationale: Per CA MTUS guidelines, NSAIDs such as Voltaren are recommended as an option for short-term symptomatic relief. A Cochrane review of the literature on drug relief for low back pain (LBP) suggested that NSAIDs were no more effective than other drugs such as acetaminophen, narcotic analgesics, and muscle relaxants. Long term use of NSAIDs is not recommended as there is no evidence of long term effectiveness for pain or function, and is associated with GI, renal and cardiac adverse effects. In this case, there is little to no documentation of any significant improvement in pain level (i.e. VAS) or function with prior use. In the absence of objective functional improvement, the medical necessity for Voltaren has not been established. Thus, the request is not medically necessary in accordance to guidelines.

Norco 10/325 mg, #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 Page(s): 74-91.

Decision rationale: Norco (Hydrocodone + Acetaminophen) is indicated for moderate to severe pain. It is classified as a short-acting opioids, often used for intermittent or breakthrough pain. Guidelines indicate "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 non-adherent) drug-related

behaviors. The guidelines state continuation of opioids is recommended if the patient has returned to work and if the patient has improved functioning and pain. The medical records do not establish failure of non-opioid analgesics, such as NSAIDs or acetaminophen, and there is no mention of ongoing attempts with non-pharmacologic means of pain management. There is little to no documentation of any significant improvement in pain level (i.e. VAS) or function with prior use to demonstrate the efficacy of this medication. There is no evidence of urine drug test in order to monitor compliance. Therefore, the medical necessity for Norco has not been established based on the guidelines.

Fioricet (Butalbital/APAP), # 60:

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 Page(s): 23.

Decision rationale: Per CA MTUS guidelines, Barbiturate-containing analgesic agents (BCAs) are not recommended for chronic pain. The potential for drug dependence is high and no evidence exists to show a clinically important enhancement of analgesic efficacy of BCAs due to the barbiturate constituents. There is a risk of medication overuse as well as rebound headache. In this case, there is no documentation of a detailed assessment of headache. There is no documentation of any significant improvement in pain level (i.e. VAS) or function with prior use to demonstrate the efficacy of this medication. Therefore, the request is considered not medically necessary per guidelines.

Fexmid 7.5 mg, # 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 Page(s): 63-64.

Decision rationale: Per guidelines, Fexmid (Cyclobenzaprine) is recommended as an option, using a short course of therapy. Limited, mixed-evidence does not allow for a recommendation for chronic use. Cyclobenzaprine is a skeletal muscle relaxant and a central nervous system depressant with similar effects to tricyclic antidepressants (e.g. Amitriptyline). Cyclobenzaprine is more effective than placebo in the management of back pain, although the effect is modest and comes at the price of adverse effects. Cyclobenzaprine has been shown to produce a modest benefit in treatment of fibromyalgia. In this case, there is little to no evidence of substantial spasm unresponsive to first line therapy. There is no documentation of significant improvement in function with continuous use. Chronic use of this medication is not recommended. Therefore, the medical necessity of the request is not established per guidelines.