

Case Number:	CM14-0050742		
Date Assigned:	06/25/2014	Date of Injury:	07/29/2008
Decision Date:	08/07/2014	UR Denial Date:	03/12/2014
Priority:	Standard	Application Received:	03/21/2014

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 Family Practice 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 52 yr. old female claimant sustained a work related injury on 7/21/08 involving the neck from a whiplash. She has a diagnosis of cervical disc displacement, chronic pain syndrome and tension headaches. She has had radiofrequency procedures, facet injections, therapy and medial branch blocks of her cervical spine. A progress note on 11/12/13 indicated the claimant had 7/10 pain with tenderness in the cervical spine, trapezial areas and rhomboid areas. She had been on Naprosyn and Cymbalta for several months. The treating physician added Flexeril 10 mg three times a day to the existing Naprosyn, Tramadol and Cymbalta (which have been used since at least Sept 2013). In January 3, 2014, the pain scales were unchanged and the aforementioned medications were continued. On 2/28/14, her pain was 6/10 with no improvement with recent acupuncture and continued medications from the prior 2 visits.

IMR ISSUES, DECISIONS AND RATIONALES

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

FLEXERIL 10 MG #90 - 2 REFILLS: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Flexeril (Cyclobenzaprine).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants Page(s): 63-65.

Decision rationale: According to the MTUS guidelines: Cyclobenzaprine (Flexeril) is more effective than placebo for back pain. It is recommended for short course therapy and has the greatest benefit in the first 4 days suggesting that shorter courses may be better. Those with fibromyalgia were 3 times more likely to report overall improvement, particularly sleep. However, in low back pain they show no benefit over NSAIDS in pain and overall improvement. The efficacy diminishes over time and there is risk of dependency. In this case, the claimant had been on Flexeril for an extended period of time without improvement in function or pain scale. Therefore, the request for Flexeril 10mg #90 with 2 refills is not medically necessary.

CYMBALTA 60MG #30 - 2 REFILLS: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Cymbalta (Duloxetine).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressants and Duloxetine Page(s): 15.

Decision rationale: It is 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. Side effects, including excessive sedation (especially that which would affect work performance) should be assessed. (Additional side effects are listed below for each specific drug.) It is recommended that these outcome measurements should be initiated at one week of treatment with a recommended trial of at least 4 weeks. The optimal duration of treatment is not known because most double-blind trials have been of short duration (6-12 weeks). It has been suggested that if pain is in remission for 3-6 months, a gradual tapering of anti-depressants may be undertaken. Selective serotonin and norepinephrine reuptake inhibitors (SNRIs): Duloxetine (Cymbalta): FDA-approved for anxiety, depression, diabetic neuropathy, and fibromyalgia. Used off-label for neuropathic pain and radiculopathy. Duloxetine is recommended as a first-line option for diabetic neuropathy. No high quality evidence is reported to support the use of duloxetine for lumbar radiculopathy. In this case, the claimant does not have neuropathy or improvement in pain, function with over 6 months use of Cymbalta. Therefore, the request for Cymbalta 60mg #30 with 2 refills is not medically necessary.

NAPROSYN 375 MG #60 - 2 REFILLS: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): 68-73.

Decision rationale: According to the MTUS guidelines, NSAIDs are recommended at the lowest dose for the shortest period for patients with moderate or severe pain in cases of chronic back pain and osteoarthritis. NSAIDs such as Naproxen are not superior to acetaminophen. There is inconsistent evidence for long-term use for neuropathic pain. The prolonged use of NSAIDs can also delay healing of soft tissues, muscles, ligaments, tendons and cartilage. NSAIDs are for acute exacerbations of low back pain it is second line to acetaminophen. In this case, the claimant had been on Naprosyn for over 6 months with no significant improvement in pain or function. In addition, there is no evidence of superiority to Tylenol or its failure. Therefore, the request for Naprosyn 375mg #60 with 2 refills is not medically necessary.

TRAMADOL 50 MG #90: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Tramadol Page(s): 93-94.

Decision rationale: According to the MTUS guidelines: 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. Tramadol is a synthetic opioid affecting the central nervous system. The immediate release formulation is recommended at a dose of 50 to 100mg by mouth every 4 to 6 hours (not to exceed 400mg/day). This dose is recommended after titrating patients up from 100mg/day, with dosing being increased every 3 days as tolerated. For patients in need of immediate pain relief, which outweighs the risk of non-tolerability the initial starting dose, may be 50mg to 100mg every 4 to 6 hours (max 400mg/day). Ultram ER: Patient currently not on immediate release tramadol should be started at a dose of 100mg once daily. The dose should be titrated upwards by 100mg increments if needed (Max dose 300mg/day). Patients currently on immediate release tramadol, calculate the 24-hour dose of IR and initiate a total daily dose of ER rounded to the next lowest 100mg increment (Max dose 300mg/day). Treatment of chronic lumbar root pain: A limitation of current studies is that there are virtually no repeated dose analgesic trials for neuropathy secondary to lumbar radiculopathy. A recent study that addressed this problem found that chronic lumbar radicular pain did not respond to either a tricyclic antidepressant or opioid in doses that have been effective for painful diabetic neuropathy or postherpetic neuralgia. Morphine was the least effective treatment (reducing leg and back pain by 1-7% compared to placebo). Sample size and drop out rate was a limitation. Not recommended as a first-line therapy for osteoarthritis. Short-term use: Recommended on a trial basis for short-term use after there has been evidence of failure of first-line non-pharmacologic and medication options (such as acetaminophen or NSAIDs) and when there is evidence of moderate to severe pain. Also recommended for a trial if there is evidence of contraindications for use of first-line medications. Weak opioids should be considered at initiation of treatment with this class of drugs (such as Tramadol, Tramadol/acetaminophen, hydrocodone and codeine), and stronger opioids are only recommended for treatment of severe pain under exceptional circumstances (oxycodone,

oxycodone, hydromorphone, fentanyl, morphine sulfate). Benefits of opioids are limited by frequent side effects (including nausea, constipation, dizziness, somnolence and vomiting). Long-term use: Under study for long-term use as there are no long-term trials. There is therefore a lack of evidence to allow for a treatment recommendation. If used on a long-term basis, the criteria for use of opioids should be followed. The claimant had been on Tramadol for over 6 months without significant clinical improvement. The claimant's diagnoses are not supported by clinical trials that support Tramadol. In addition, there is a lack of evidence of long-term use of Tramadol. Therefore, the request for Tramadol 50mg #90 is not medically necessary.