

Case Number:	CM14-0188503		
Date Assigned:	11/19/2014	Date of Injury:	02/14/2000
Decision Date:	02/11/2015	UR Denial Date:	10/23/2014
Priority:	Standard	Application Received:	11/12/2014

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 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 members DOI is listed as 2/14/2000. No details are available as to the nature of the members injury or specifics of treatments and interventions apart from the included PTP notes covering the last year. The most distant report is dated 9/24/13. The member indicated that without medications his pain was 10/10 and with the medications was 5-6/10. This was sufficient to allow him to function in his ADL's. He reports with medications that he can walk for block, stand for 15 minutes, sit for 10 minutes and lift 10 lbs. There are limited details as to the physical exam being broad statements. He has limited ROM, he has 4/5 strength, there is decreased sensation to light touch (location not localizing and listed as "right to left"). He is tender to palpation in the lumbar spinous processes. No details are available with regard to radiologic evaluation or prior procedures. Medications are listed as Flexeril 10mg hs, Voltaren gel qid for local pain control, Arthrotec 75mg bid for inflammation and Norco 10/325 qid for pain control. No mention is made of the past use of anti-epileptic or antidepressant medications as adjuncts to pain control. No mention is made of other modalities such as home exercise, PT, Chiro, Acupuncture or ESI. Nothing specific was listed as to the diagnoses being treated. The most recent available report dates to 10/15/2014. The diagnoses of interest were listed as Pain in Joint, Lower Leg (the specific limb and joint are not specified), Lumbago and Cervicalgia. At this visit pain control with medications is reported as 4/10 he could only walk < block and lift < 10 lbs. The reported physical exam is unchanged. The treatments requested remain medications only and the only change in the medications has been an increase in Flexeril 10mg to bid from qhs. The issues under consideration involve Norco with a modification to 90 tabs from the requested 120 and flexeril with a straightforward non-certification.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 prescription of Norco 10/325mg #120: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 11, 13, 14, 79-81, 86, 87, 93, 95.

Decision rationale: A therapeutic trial of opioids should not be employed until the patient has failed a trial of non-opioid analgesics. Opioids, for long-term use, cannot be supported as there is a lack of evidence to allow for a treatment recommendation. A meta-analysis found that opioids were more effective than placebo for reducing pain intensity but the benefit for physical function was small and was considered questionable for clinical relevance. Opioids can be recommended on a trial basis for short-term use after there has been evidence of failure of first-line medication options such as acetaminophen or NSAIDs when there is evidence of moderate to severe pain. If the listed diagnosis of "Lumbago" was in fact used to describe radicular/neuropathic pain then antidepressants would be considered first line agents unless found to be ineffective, poorly tolerated or otherwise contra-indicated. They represent a proven alternative and can be an option in non-neuropathic pain when associated with a diagnosis of depression as well as chronic LBP syndromes. If chronic use of opioids is entertained, then before initiating therapy, the patient should set goals, and the continued use of opioids should be contingent on meeting these goals. Baseline pain and functional assessments should be made. Function should include social, physical, psychological, daily and work activities. Continuation of the use of opioids would be best assessed on the basis of a return to work with evidence for improved functioning and reduced pain. The primary risk with continued use is that 36 to 56% of users have a lifetime risk for substance use disorders. Additionally there is the risk of diversion, tolerance and hyperalgesia resulting in gradual increases in medication dosing and evidence for decreasing benefits. With continuous pain extended-release opioids are recommended rather than short acting narcotic formulations. Patients on this modality may require a dose of "rescue" opioids. The need for extra opioid can be a guide to determine the sustained release dose required. In this instance use of Norco was functioning as a qid maintenance medication. Norco is considered a member of the short-acting family of opioids and as such faces a much higher risk of rebound pain and subsequent misuse. This is not an appropriate use of short duration opioids. Weaning of opioid analgesics is recommended if there is no overall improvement in function, unless there are extenuating circumstances. This member was found to have had a stable condition with no documented evidence for a sustained reduction in pain or improvement in practical function related to the use of opioids over an extended period of time. In fact there appeared to have been a decline in function in regard to walking distance and lifting ability. In the face of evidence for limited utility for improved function, recommendations for short term use of short acting opioids and the ongoing risk for rebound pain and dependence, continued use of Norco should not be supported. A decrease in dose and transition to more relevant medications for the long term management of pain with AED's or ADD's would be important. The request of prescription of Norco 10/325mg #120 is not medically necessary.

1 prescription of Flexeril 10mg, #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 60,63.

Decision rationale: The general class of agents used as muscle relaxants are generally recommended for short term use only and with caution due to side effects as second line agents for patients with exacerbations of back pain. There is no evidence that they will show a benefit beyond that of NSAID's or that there is any additional benefit in combination with NSAID's. Efficacy appears to diminish with time and maximal benefit appears to decline after approximately 4 days. Sedation is the most common class effect and needs to be considered in those having to drive or operate heavy equipment. No description of side effects (or their absence) is reported. No description of muscle spasms is available from the notes with regard to location, duration, impact on function and ADL's or the benefit of Flexeril. Based on the short-term indications for use of this class of agent and failure to show evidence for improved function use of Flexeril cannot be supported. . The request is not medically necessary.