

Case Number:	CM14-0192215		
Date Assigned:	11/25/2014	Date of Injury:	10/30/2003
Decision Date:	02/18/2015	UR Denial Date:	11/01/2014
Priority:	Standard	Application Received:	11/17/2014

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: Indiana

Certification(s)/Specialty: Preventive Medicine, Occupational Medicine

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

This employee is a 76 year old female with date of injury of 10/30/2003. A review of the medical records indicate that the patient is undergoing treatment for intervertebral disc disease of the cervical and lumbar spine and right shoulder sprain/strain. Subjective complaints include continued pain in the right shoulder and neck and low back. Objective findings include limited range of motion of the cervical and lumbar spine with tenderness to palpation of the paravertebrals and positive straight leg raise bilaterally; tenderness to right shoulder with positive Neer's and Hawkins. Treatment has included Flexmid, Anaprox, Fioricet, Norco, Ultra, and compound creams. The utilization review dated 11/1/2014 non-certified Flexmid, Fioricet, Nalfon, topical compound cream, Maxalt, Ambien, and TENS unit batteries.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 prescription of Fexmid (Cyclobenzaprine) 7.5mg, #120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Cyclobenzaprine, Medications for chronic pain, Antispasmodics Page(s): 41-42, 60-61, 64-66. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Cyclobenzaprine (Flexeril®); UpToDate, Flexeril

Decision rationale: MTUS Chronic Pain Medical Treatment states for Cyclobenzaprine, "Recommended as an option, using a short course of therapy. . . The effect is greatest in the first 4 days of treatment, suggesting that shorter courses may be better. (Browning, 2001) Treatment should be brief." The medical documents indicate that patient is far in excess of the initial treatment window and period. Additionally, MTUS outlines that "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 should 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 medications should show effects within 1 to 3 days, and the analgesic effect of antidepressants should occur within 1 week. A record of pain and function with the medication should be recorded. (Mens, 2005)" UpToDate "Flexeril" also recommends "Do not use longer than 2-3 weeks". Medical documents do not fully detail the components outlined in the guidelines above and do not establish the need for long term/chronic usage of cyclobenzaprine. Official Disability Guidelines states regarding Cyclobenzaprine, "Recommended as an option, using a short course of therapy . . . The addition of cyclobenzaprine to other agents is not recommended." Several other pain medications are being requested, along with Cyclobenzaprine, which Official Disability Guidelines recommends against. As such, the request for Fexmid 7.5mg #120 is not medically necessary.

Fioricet (Butalbital/APAP/Caffeine) 50/325/40mg, #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Barbiturate containing analgesic agents Page(s): 23.

Decision rationale: Fioricet (Butalbital/APAP/Caffeine) 50/325/40mg is classified as a barbiturate containing analgesic agents (BCA's). MTUS states the following: "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. (McLean, 2000) There is a risk of medication overuse as well as rebound headache." Therefore, the request for Fioricet (Butalbital/APAP/Caffeine) 50/325/40mg, #60 is not medically necessary.

Nalfon 400mg, #90: 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 NSAIDs (non-steroidal anti-inflammatory drugs) Page(s): 67-73. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain (Chronic), Naproxen, NSAIDs (non-steroidal anti-inflammatory drugs)

Decision rationale: Nalfon is an NSAID. MTUS specifies four recommendations regarding NSAID use: 1) Osteoarthritis (including knee and hip): Recommended at the lowest dose for the shortest period in patients with moderate to severe pain. 2) Back Pain - Acute exacerbations of chronic pain: Recommended as a second-line treatment after acetaminophen. In general, there is conflicting evidence that NSAIDs are more effective than acetaminophen for acute LBP. 3) Back Pain - Chronic low back pain: 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. The review also found that NSAIDs had more adverse effects than placebo and acetaminophen but fewer effects than muscle relaxants and narcotic analgesics. 4) 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. The medical documents do not indicate that the patient is being treated for osteoarthritis. Additionally, the treating physician does not document failure of primary (Tylenol) treatment. MTUS guidelines recommend against long-term use. As such, the request for Nalfon 400mg, #90 is not medically necessary.

30gm and 120gm Flurbiprofen 25% - Menthol 10% - Camphor 3% - Capsaicin 0.0375% topical compound cream: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Compound creams

Decision rationale: MTUS and Official Disability Guidelines recommend usage of topical analgesics as an option, but also further details "primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed." The medical documents do not indicate failure of antidepressants or anticonvulsants. MTUS states, "There is little to no research to support the use of many of these agents. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended." MTUS states that the only FDA- approved NSAID medication for topical use includes diclofenac, which is indicated for relief of osteoarthritis pain in joints. Flurbiprofen would not be indicated for topical use in this case. Therefore, the request for 30gm and 120gm Flurbiprofen 25% - Menthol 10% - Camphor 3% - Capsaicin 0.0375% topical compound cream is not medically necessary.

Maxalt: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation EFNS guideline; Evers S, Afra J, Frese A, Goadsby PJ, Linde M, May A, Sandor PS, European Federation of Neurological Societies. EFNS guideline on the drug treatment of migraine--revised report of an EFNS task force. Eur J Neurol. 2009 Sep;16(9):968-81

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Head, Rizatriptan (Maxalt®), Triptans

Decision rationale: MTUS is silent specifically with regards to Malaxt and triptans for migraine treatment. Other guidelines were utilized. Official Disability Guidelines states regarding Rizatriptan, "Recommended for migraine sufferers." Official Disability Guidelines additionally writes regarding triptans, "At marketed doses, all oral triptans (e.g., Sumatriptan, brand name Imitrex) are effective and well tolerated. Differences among them are in general relatively small, but clinically relevant for individual patients. A poor response to one triptan does not predict a poor response to other agents in that class." Medical records indicate complaints of headaches but there is no documentation that they are migraines. As such, the request for Maxalt is not medically necessary.

Ambien (Zolpidem) 5mg #60: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines Treatment Integrated/Disability Duration Guidelines Pain (Chronic)

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Zolpidem, insomnia treatment

Decision rationale: The California MTUS is silent regarding this topic. Official Disability Guidelines states that Zolpidem is a prescription short acting non-benzodiazepine hypnotic, which is approved for short-term treatment of insomnia. In this case, the patient has been taking this medication for several months. There has been no discussion of the patient's sleep hygiene or the need for variance from the guidelines, such as "a) Wake at the same time everyday; (b) Maintain a consistent bedtime; (c) Exercise regularly (not within 2 to 4 hours of bedtime); (d) Perform relaxing activities before bedtime; (e) Keep your bedroom quiet and cool; (f) Do not watch the clock; (g) Avoid caffeine and nicotine for at least six hours before bed; (h) Only drink in moderation; & (i) Avoid napping." Medical documents also do not include results of these first line treatments, if they were used in treatment of the patient's insomnia. Official Disability Guidelines additionally states "The specific component of insomnia should be addressed: (a) Sleep onset; (b) Sleep maintenance; (c) Sleep quality; & (d) Next-day functioning." Medical documents provided do not detail these components. As such, the request for Ambien is not medically necessary at this time.

Replacement of batteries and supplies for TENS unit: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 287-315, Chronic Pain Treatment Guidelines Interferential Current Stimulation, Transcutaneous electrotherapy Page(s): 54, 114-116, 118-120.

Decision rationale: ACOEM guidelines state "Insufficient evidence exists to determine the effectiveness of sympathetic therapy, a noninvasive treatment involving electrical stimulation, also known as interferential therapy. At-home local applications of heat or cold are as effective as those performed by therapists." MTUS further states regarding interferential units, "Not recommended as an isolated intervention" and details the criteria for selection:- Pain is ineffectively controlled due to diminished effectiveness of medications; or - Pain is ineffectively controlled with medications due to side effects; or - History of substance abuse; or - Significant pain from postoperative conditions limits the ability to perform exercise programs/ physical therapy treatment; or- Unresponsive to conservative measures (e.g., repositioning, heat/ice, etc.). "If those criteria are met, then a one-month trial may be appropriate to permit the physician and physical medicine provider to study the effects and benefits."The treating physician's progress notes do no indicate that the patients has poorly controlled pain, concerns for substance abuse, pain from postoperative conditions that limit ability to participate in exercise programs/treatments, or is unresponsive to conservative measures. As such, current request for a TENS unit is not medically necessary.