

Case Number:	CM14-0194450		
Date Assigned:	12/02/2014	Date of Injury:	08/25/2006
Decision Date:	01/14/2015	UR Denial Date:	10/27/2014
Priority:	Standard	Application Received:	11/20/2014

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 Internal Medicine and is licensed to practice in Virginia and Washington. 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 injured worker is a 38 year old male who sustained a work related injury August 25, 2006. A primary care physician's progress report dated September 22, 2014, finds the injured worker presenting for a follow-up visit. He complains of lower back pain without improvement and more pain again in the bilateral knees. Assessment is documented as chronic pain with diagnoses of; lumbago, insomnia unspecified, other pain disorders related to psychological factors, and lumbosacral disc degeneration without documented physical assessment. Treatment is documented as refill medications; Fentanyl Patch, Nucynta, Halcion, and Soma. Work status documented as, remain off work. On October 20, 2014, the injured worker returns with complaints of lower back pain with spasm and no improvements. The primary treating physician documents that the injured worker has undergone many withdraws as his medication has not been approved and he would like other alternatives, if possible. Treatment is documented as; Fentanyl Patch, Nucynta, Soma, Halica refill, and prescriptions for Norco 10/325 PO QID #120 and Flexeril 10 mg PO QID #120. Work status is documented as remain off work until November 17, 2014. There is no physical examination documentation present for this office visit. According to utilization review performed October 27, 2014, it is unclear from the medical records provided, how long the injured worker has been on Norco and Flexeril. There is no pain contract, pill count, behavioral evaluation, CURES report, or recent urine drug screen documented. Citing MTUS, the ongoing management with opioids requires evidence of pain relief, functional gain and appropriate medication use in the absence of side effect or aberrant drug taking behaviors. Citing MTUS, muscle relaxants are generally indicated for short term treatment of acute pain exacerbations. Cyclobenzaprine is not recommended to be used for longer than two to three weeks. The documentation failed to specify length of treatment. The

current quantity requested exceeds the guideline provisions. Therefore, Norco and Flexeril were non-certified.

IMR ISSUES, DECISIONS AND RATIONALES

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

Flexeril 10mg, #120: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 9792
Page(s): 41-42,64.

Decision rationale: Per MTUS, Cyclobenzaprine (Flexeril, Amrix, Fexmid™, generic available): Recommended for 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. It has a central mechanism of action, but it is not effective in treating spasticity from cerebral palsy or spinal cord disease. Cyclobenzaprine is associated with a number needed to treat of 3 at 2 weeks for symptom improvement. The greatest effect appears to be in the first 4 days of treatment. (Browning, 2001) (Kinkade, 2007) (Toth, 2004) See Cyclobenzaprine. Cyclobenzaprine has been shown to produce a modest benefit in treatment of fibromyalgia. Cyclobenzaprine-treated patients with fibromyalgia were 3 times more likely to report overall improvement and to report moderate reductions in individual symptoms (particularly sleep). A meta-analysis concluded that the number needed to treat for patients with fibromyalgia was 4.8. (ICSI, 2007) (Tofferi, 2004) Side Effects: Include anticholinergic effects (drowsiness, urinary retention and dry mouth). Sedative effects may limit use. Headache has been noted. This medication should be avoided in patients with arrhythmias, heart block, heart failure and recent myocardial infarction. Side effects limit use in the elderly. (See, 2008) (Toth, 2004) Dosing: 5 mg three times a day. Can be increased to 10 mg three times a day. This medication is not recommended to be used for longer than 2-3 weeks. (See, 2008) From the clinical documentation provided, this medication would not be indicated.

Norco 10/325mg, #120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, specific drug list.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 9792
Page(s): 75,91,87-89.

Decision rationale: Per MTUS, Hydrocodone/Acetaminophen (Anexsia, Co-Gesic, Hycet™; Lorcet, Lortab; Margesic-, Maxidone™; Norco, Stagesic, Vicodin, Xodol, Zydone; generics

available): Indicated for moderate to moderately severe pain. Note: there are no FDA-approved hydrocodone products for pain unless formulated as a combination. Side Effects: See opioid adverse effects. Analgesic dose: The usual dose of 5/500mg is 1 or 2 tablets PO every four to six hours as needed for pain (Max 8 tablets/day). For higher doses of hydrocodone (>5mg/tab) and acetaminophen (>500mg/tab) the recommended dose is usually 1 tablet every four to six hours as needed for pain. Hydrocodone has a recommended maximum dose of 60mg/24 hours. The dose is limited by the dosage of acetaminophen, which should not exceed 4g/24 hours.

CRITERIA FOR USE OF OPIOIDS

Long-term Users of Opioids (6-months or more)

1) Re-assess

(a) Has the diagnosis changed? (b) What other medications is the patient taking? Are they effective, producing side effects? (c) What treatments have been attempted since the use of opioids? Have they been effective? For how long? (d) Document pain and functional improvement and compare to baseline. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. Information from family members or other caregivers should be considered in determining the patient's response to treatment. Pain should be assessed at each visit, and functioning should be measured at 6-month intervals using a numerical scale or validated instrument. (e) Document adverse effects: constipation, nausea, vomiting, headache, dyspepsia, pruritis, dizziness, fatigue, dry mouth, sweating, hyperalgesia, sexual dysfunction, and sedation. (f) Does the patient appear to need a psychological consultation? Issues to examine would include motivation, attitude about pain/work, return-to-work, social life including interpersonal and work-related relationships. (g) Is there indication for a screening instrument for abuse/addiction. See Substance Abuse Screening.

2) Strategy for maintenance

(a) Do not attempt to lower the dose if it is working (b) Supplemental doses of break-through medication may be required for incidental pain, end-of dose pain, and pain that occurs with predictable situations. This can be determined by information that the patient provides from a pain diary or evaluation of additional need for supplemental medication. (c) The standard increase in dose is 25 to 50% for mild pain and 50 to 100% for severe pain (Wisconsin)

3) Visit Frequency

(a) There is no set visit frequency. This should be adjusted to the patient's need for evaluation of adverse effects, pain status, and appropriate use of medication, with recommended duration between visits from 1 to 6 months. Washington, 2002) (Colorado, 2002) (Ontario, 2000) (VA/DoD, 2003) (Maddox-AAPM/APS, 1997) (Wisconsin, 2004) (Warfield, 2004) The patient did not demonstrate clinical improvement while on this medication; long term usage would not be indicated.