

| | | | |
|-----------------------|--------------|------------------------------|------------|
| Case Number: | CM14-0200885 | | |
| Date Assigned: | 12/11/2014 | Date of Injury: | 07/23/2013 |
| Decision Date: | 02/05/2015 | UR Denial Date: | 11/17/2014 |
| Priority: | Standard | Application Received: | 12/01/2014 |

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 Occupational Medicine, has a subspecialty in ENTER SUBSPECIALTY 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:

35 year old female patient transporter injured her neck and upper back at work on 23 July 2013. Premorbid conditions included chronic low back pain status post L5-S1 artificial disc replacement (2007), depression, bi-polar personality disorder, obesity (BMI 37). At her last provider visit on 19 Nov 2014 she complained of pain with medications as 9/10 and pain without medications also a 9/10. She feels a functional benefit from the medications in that she is able to perform self care and household tasks. Examination of the cervical spine showed loss of normal lordosis and restricted range of motion to flexion, extension and lateral rotation (left and right). Spurling's sign was negative for radicular symptoms. Thoracic spine exam showed paravertebral muscle spasms and tenderness. Lumbar spine exam showed restricted range of motion to flexion, extension and lateral rotation (left and right). Upper extremity sensation was decreased to light touch over C-5 dermatome. Upper extremity deep tendon reflexes and motor strength were normal. Neck MRI (14 Jun 2014) showed mild degenerative disc disease at C5-6 and mild left facet arthropathy at C2-3. Thoracic MRI (30 August 2013) showed left paramedian T6-7 disc protrusion and scoliosis with moderate spondylosis. Thoracic spine X-ray ((19 Aug 2013) showed moderate spondylosis, progressive since 2008. Random drug screens are consistent with patient's medications. Treatment has included physical therapy, psychologist care for support of pain management (coping skills, depressed mood), acupuncture, TENS, functional restoration program, thoracic epidural steroid injection and medication (Naprosyn, Protonix, morphine sulfate, Norco, gabapentin, Flexeril, ibuprofen, Xanax, Wellbutrin, Duragesic patch). Present medications are Norco (begun over 1 year ago - 4 tabs per day), Flexeril (begun over 1 year ago), gabapentin, ibuprofen, Xanax and Wellbutrin. The patient has a pain medication contract with the provider and does not display aberrant drug-seeking behavior.

IMR ISSUES, DECISIONS AND RATIONALES

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

Norco 10/325 mg #60: Overturned

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment Page(s): 49, Chronic Pain Treatment Guidelines Medications for Chronic Pain, Opioids Page(s): 60, 74-96.

Decision rationale: Norco is a mixed medication made up of the opioid, Hydrocodone, and Acetaminophen, better known as Tylenol. It is recommended for moderate to moderately severe pain with usual dosing of 5-10 mg Hydrocodone per 325 mg of Acetaminophen taken as 1-2 tablets every 4-6 hours. Maximum dose according to the MTUS is limited to 4 gm of Acetaminophen per day which is usually 60mg/day of Hydrocodone. According to the MTUS, opioid therapy for control of chronic pain, while not considered first line therapy, is considered a viable alternative when other modalities have been tried and failed. Success of this therapy is noted when there is significant improvement in pain or function. The risk with this therapy is the development of addiction, overdose and death. The MTUS Chronic Pain guidelines do address this issue and has a number of recommendations to identify when addiction develops and to prevent addiction from occurring. The present provider is appropriately monitoring this patient and notes the improvement in patient's function with the use of opioid preparations. The records also document stability in dosing, in that the same dose or lower of opioid the patient was taking 6 months ago is still in present use. This is not the pattern you will see in addiction. Since the patient is not displaying signs of addiction, the medication is effective in improving the patient's function and the patient is being appropriately monitored by the treating provider, chronic use of opioids in this instance is not contraindicated.

Flexeril/Cyclobenzaprine 10 mg #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment Page(s): 47, Chronic Pain Treatment Guidelines Cyclobenzaprine (Flexeril), Muscle Relaxants (For Pain) Page(s): 41-42, 63.

Decision rationale: Cyclobenzaprine (Flexeril) is classified as a sedating skeletal muscle relaxant. It is recommended to be used three times per day. This class of medications can be helpful in reducing pain and muscle tension thus increasing patient mobility. Muscle relaxants as a group, however, are recommended for short-term use only as their efficacy appears to diminish over time. In fact, studies have shown cyclobenzaprine's greatest effect is in the first 4 days of treatment after which use may actually hinder return to functional activities. Muscle

relaxants are considered no more effective at pain control than non-steroidal anti-inflammatory medication (NSAIDs) and there is no study that shows combination therapy of NSAIDs with muscle relaxants has a demonstrable benefit. This patient has been on muscle relaxant therapy for over 6 months. There are no indications that this medication has added to the patient's present level of function. Medical necessity for continued use of muscle relaxants (as a class) or Flexeril (specifically) has not been established.