

Case Number:	CM14-0201607		
Date Assigned:	12/12/2014	Date of Injury:	07/21/2005
Decision Date:	01/29/2015	UR Denial Date:	11/21/2014
Priority:	Standard	Application Received:	12/02/2014

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 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 patient is a 59 year old female with a date of injury of 07/21/2005. That day she had an evaluation for both wrists/hands for carpal tunnel syndrome. In 2004 she had bilateral carpal tunnel release surgery. Tinel's sign was present bilaterally and tenosynovitis was diagnosed. On 05/15/2007 she had left knee arthroscopic partial lateral and medial meniscectomy with debridement of the lateral femoral condyle. On 08/03/2007 she was 10 weeks after previous left knee surgery and had physical therapy. On 10/03/2007 she was P&S for her left knee after surgery and rehab. On 10/16/2007 she had left knee pain. She had a previous meniscectomy from an injury in 2005. She has lumbar disc disease and left knee pain. She has been taking Ibuprofen, Norco and Flexeril since at least 12/18/2007 when she weighed 273 pounds and 08/19/2008 when she weighed 278 pounds. On 02/26/2009 she had a total left knee arthroplasty. On 10/15/2012 she had mild bilateral carpal tunnel syndrome on EMG/NCS. She had evaluations on 10/10/2014 and 11/14/2014 that noted the back and left knee pain with no objective findings and her medication was renewed. There was no evidence of functional improvement.

IMR ISSUES, DECISIONS AND RATIONALES

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

Norco 10/325mg: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids On-Going Management Page(s): 78 and 79.

Decision rationale: Chronic Pain Medical Treatment Guidelines MTUS (Effective July 18, 2009) page 78. On-Going Management. Actions Should Include: (a) Prescriptions from a single practitioner taken as directed, and all prescriptions from a single pharmacy. (b) The lowest possible dose should be prescribed to improve pain and function. (c) Office: Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. Pain assessment should include: current pain; the least reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid; how long it takes for pain relief; and how long pain relief lasts. 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. The 4 A's for Ongoing Monitoring: Four domains have been proposed as most relevant for ongoing monitoring of chronic pain patients on opioids: pain relief, side effects, physical and psychosocial functioning, and the occurrence of any potentially aberrant (or nonadherent) drug-related behaviors. These domains have been summarized as the "4 A's" (analgesia, activities of daily living, adverse side effects, and aberrant drug taking behaviors). The monitoring of these outcomes over time should affect therapeutic decisions and provide a framework for documentation of the clinical use of these controlled drugs. (Passik, 2000) (d) Home: To aid in pain and functioning assessment, the patient should be requested to keep a pain diary that includes entries such as pain triggers, and incidence of end-of-dose pain. It should be emphasized that using this diary will help in tailoring the opioid dose. This should not be a requirement for pain management. (e) Use of drug screening or inpatient treatment with issues of abuse, addiction, or poor pain control. (f) Documentation of misuse of medications (doctor-shopping, uncontrolled drug escalation, drug diversion). (g) Continuing review of overall situation with regard to nonopioid means of pain control. (h) Consideration of a consultation with a multidisciplinary pain clinic if doses of opioids are required beyond what is usually required for the condition or pain does not improve on opioids in 3 months. Consider a psych consult if there is evidence of depression, anxiety or irritability. Consider an addiction medicine consult if there is evidence of substance misuse. There is insufficient documentation to substantiate that the above criteria were met. Continued Norco treatment is not medically necessary.

Flexeril 10mg: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants Page(s): 63 - 66.

Decision rationale: Chronic Pain Medical Treatment Guidelines (Effective July 18, 2009) Page 63. Muscle relaxants (for pain) recommend non-sedating muscle relaxants with caution as a second-line option for short-term treatment of acute exacerbations in patients with chronic LBP. Muscle relaxants may be effective in reducing pain and muscle tension, and increasing mobility.

However, in most LBP cases, they show no benefit beyond NSAIDs in pain and overall improvement. Also there is no additional benefit shown in combination with NSAIDs. Efficacy appears to diminish over time, and prolonged use of some medications in this class may lead to dependence. (Homik, 2004) Sedation is the most commonly reported adverse effect of muscle relaxant medications. These drugs should be used with caution in patients driving motor vehicles or operating heavy machinery. Drugs with the most limited published evidence in terms of clinical effectiveness include Chlorzoxazone, Methocarbamol, Dantrolene and Baclofen. (Chou, 2004) According to a recent review in American Family Physician, skeletal muscle relaxants are the most widely prescribed drug class for musculoskeletal conditions (18.5% of prescriptions), and the most commonly prescribed antispasmodic agents are Carisoprodol, Cyclobenzaprine, Metaxalone, and Methocarbamol, but despite their popularity, skeletal muscle relaxants should not be the primary drug class of choice for musculoskeletal conditions. (See2, 2008). As noted above long term treatment with muscle relaxants is not consistent with MTUS guidelines. Also, she has been taking NSAIDS with Flexeril and the addition of a muscle relaxant to NSAIDS treatment frequently is not associated with any objective improvement. Therefore, this request is not medically necessary.