

Case Number:	CM14-0088148		
Date Assigned:	07/23/2014	Date of Injury:	03/02/2010
Decision Date:	01/30/2015	UR Denial Date:	06/02/2014
Priority:	Standard	Application Received:	06/12/2014

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 North Carolina. 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:

This is a 62 year old female that was injured on 3/2/10 while walking into the building to go to work when her heel of her shoe got caught in the cracks of the gout of the brickwork and she fell with a great force falling on her right side, shattering her right arm and shoulder. Her current diagnoses consist of right shoulder adhesive capsulitis, right shoulder proximal humerus fracture, status post open reduction and inter fixation in 2010 and status post right shoulder arthroscopy in 2012. Current treatments consist of Surgery, physical therapy, MRI's and medications. According to the progress note submitted the treating physician noted that the injured worker complained of low back pain radiating down her left leg. The pain was aggravated with prolonged walking, sitting, bending, stooping and kneeling. Numbness, tingling and camping was noted in the left leg. Tenderness was noted in the lumbar spine. The injured worker was diagnosed with a lumbar disc protrusion and lumbar stenosis. The treating physician recommended physical therapy for the lumbar spine. At this time the treating physician is requesting Flexeril 10mg#30 for spasms and Tramadol 50mg #30 for pain which was denied at UR on 6/2/14 by the reviewing physician. Flexeril 10mg, 1 po qhs prn for spasms #30 was denied by the reviewing physician using CA MTUS, Muscle Relaxants guidelines which states this medication is a muscle relaxant and is for short term use not to exceed 2-3 weeks. The reviewing physician determined the requested amount exceeded the guidelines. Tramadol 50mg, 1 po qd prn for pain #30 was denied by the reviewing physician using CA MTUS, Opioids which states the use of opioid medications has to be closely monitored and documented as directed by guidelines. The reviewing physician determined that the submitted documentation did not support the guidelines.

IMR ISSUES, DECISIONS AND RATIONALES

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

Flexeril 10mg, 1 po (by mouth) QHS (every night at bedtime) prn (as needed) for spasm, #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants(for pain) Page(s): 63-64.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines muscle relaxants Page(s): 63-65.

Decision rationale: The California chronic pain medical treatment guidelines section on muscle relaxants states:Recommend non-sedating muscle relaxants with caution as a second-line option for short-term treatment of acute exacerbations in patients with chronic LBP. (Chou, 2007) (Mens, 2005) (Van Tulder, 1998) (van Tulder, 2003) (van Tulder, 2006) (Schnitzer, 2004) (See, 2008) 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) 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).This medication is not intended for long-term use per the California MTUS. The medication has not been prescribed for the flare-up of chronic low back pain. This is not an approved use for the medication. For these reasons, criteria for the use of this medication have not been met. Therefore the request is not certified.

Tramadol 50mg, take one po (by Mouth) QD (every day) prn (as needed) for pain, #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines On-Going Management; Opioids, specific drug list; Weaning of Medic.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines opioids Page(s): 76-84.

Decision rationale: The California chronic pain medical treatment guidelines section on opioids states for ongoing management: 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: currentpain; the least reported pain over the period since last assessment; average pain; intensityof 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.

When to Continue Opioids

(a) If the patient has returned to work

(b) If the patient has improved functioning and pain (Washington, 2002) (Colorado, 2002) (Ontario, 2000) (VA/DoD, 2003) (Maddox- AAPM/APS, 1997) (Wisconsin, 2004) (Warfield, 2004) - Chronic back pain: Appears to be efficacious but limited for short-term pain relief, and long term efficacy is unclear (>16 weeks), but also appears limited. Failure to respond to a time limited course of opioids has led to the suggestion of reassessment and consideration of alternative therapy. There is no evidence to recommend one opioid over another. In patients taking opioids for back pain, the prevalence of lifetime substance use disorders has ranged from 36% to 56% (a statistic limited by poor study design). Limited information indicated that up to one-fourth of patients who receive opioids exhibit aberrant medication-taking behavior. (Martell-Annals, 2007) (Chou, 2007) The long-term use of this medication class is not recommended per the California MTUS unless there documented evidence of benefit with measurable outcome measures and improvement in function. The most recent progress reports do not mention the patient's work status. There is no included objective improvement in pain such as VAS scores. There is no mention of objective functional improvement. For these reasons the criteria set forth above of ongoing and continued use of opioids have not been met. Therefore the request is not certified.