MAXIMUS Federal Services

Case Number:	CM15-0004745		
Date Assigned:	02/17/2015	Date of Injury:	05/27/2009
Decision Date:	04/03/2015	UR Denial Date:	12/08/2014
Priority:	Standard	Application Received:	01/09/2015

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: New York
Certification(s)/Specialty: Anesthesiology

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 (IW) is a 54 year old female who sustained an industrial injury on 05/27/2009. She has reported ongoing complaints of neck and low back pain. Diagnoses include cervicalgia, cervical radiculopathy; cervical disc protrusion; lumbago; lumbar radiculopathy; lumbar disc protrusion; lumbar facet dysfunction; headache and carpal tunnel syndrome. Treatment to date include chiropractic care, use of a TENS (Transcutaneous Electrical Nerve Stimulation) unit and medications. A progress note from the treating provider dated 11/05/2014 indicates examination of the neck showed weakness with the left grip, tenderness to palpation over the cervical paraspinal muscles, upper trapezius, scapular boarder; lumbar paraspinal muscles; and sacroiliac joint region. Sensation to light touch was decreased in the right fifth digit and decreased in the left foot and ankle. Straight leg raising test was positive in to both legs. An EMG/NCV (electromyogram/ nerve conduction velocity) test of 2/2013 showed indications of carpal tunnel and signals of right -sided C7 plus or minus C8 radiculopathy on the right. MRI's from March 2010 and September 2013 showed disc herniation in the cervical spine. Treatment plans included a cervical epidural steroid injection, chiropractic therapy, and refills of medications. On 12/08/2014 Utilization Review modified a request for Flexeril 10mg QTY: 30.00 to Flexeril 10mg QTY # 15. The MTUS Guidelines were cited. On 12/08/2014 Utilization Review modified a request for Norco 10/325mg QTY: 30.00 to certify Norco 10/325mg QTY #15 for weaning. The MTUS Guidelines were cited. On 12/08/2014 Utilization Review non-certified a request for Relafen 500mg QTY: 60.00. The MTUS

Guidelines were cited. On 12/08/2014 Utilization Review modified a request for Savella 12.5mg QTY: 30.00 to Savella 12.5mg QTY #30. The Official Disability Guidelines were cited.

IMR ISSUES, DECISIONS AND RATIONALES

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

Norco 10/325mg QTY: 30.00: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 78-78, 88, 91. Decision based on Non-MTUS Citation Official Disability Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 91-97. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Opioids.

Decision rationale: According to MTUS and ODG, Norco 5/325mg (Hydrocodone/ Acetaminophen) is a short-acting opioid analgesic indicated for moderate to moderately severe pain, and is used to manage both acute and chronic pain. The treatment of chronic pain with any opioid analgesic requires review and documentation of pain relief, functional status, appropriate medication use, and side effects. A pain assessment should include current pain, intensity of pain after taking the opiate, and the duration of pain relief. In this case, there is no documentation of the medication's pain relief effectiveness, functional status, or response to ongoing opioid analgesic therapy. Medical necessity of the requested item has not been established. Of note, discontinuation of an opioid analgesic should include a taper, to avoid withdrawal symptoms. The certification of the requested medication is not recommended.

Savella 12.5mg QTY: 30.00: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines.

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

Decision rationale: According to ODG, Savella is FDA approved, but under study for the treatment of fibromyalgia. In this case, the patient had prior use of Savella without any documentation of significant improvement. In this case, there was no documentation of subjective or objective benefit from use of this medication. There is no documentation of functional improvement from any previous use of this medication. Medical necessity of the requested medication has not been established. The request for Savella is not medically necessary.

Flexeril 10mg QTY: 30.00: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 41.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants Page(s): 41. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Muscle Relaxants.

Decision rationale: According to the reviewed literature, Flexeril (Cyclobenzaprine) is a muscle relaxant and is not recommended for the long-term treatment of chronic pain. Muscle relaxants may be effective in reducing pain and muscle tension, and increasing mobility. According to CA MTUS Guidelines, muscle relaxants are not considered any more effective than non-steroidal anti-inflammatory drugs (NSAIDs) alone, or in combination with NSAIDs. The medication has its greatest effect in the first four days of treatment. In this case, there is no documentation of the medication's pain relief effectiveness, functional status, or response to ongoing opioid analgesic therapy. There is insufficient data presented to support the ongoing use of this medication. In addition, this medication is not indicated for the once a day use. Medical necessity for the requested medication has not been established. The requested item is not medically necessary.

Relafen 500mg QTY: 60.00: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 72.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): 67-71. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) NSAIDs.

Decision rationale: Relafen is a non-specific non-steroidal anti-inflammatory drug (NSAID). Oral NSAIDs are recommended for the treatment of chronic pain and control of inflammation as a second-line therapy after acetaminophen. ODG states that NSAIDs are recommended for acute pain, osteoarthritis, acute low back pain (LBP) and acute exacerbations of chronic pain, short-term pain relief in chronic LBP, and short-term improvement of function in chronic LBP. There is no evidence of long-term effectiveness for pain or function. There is inconsistent evidence for the use of NSAIDs to treat long-term neuropathic pain. Guidelines recommended that the lowest effective dose be used for the shortest duration of time consistent with treatment goals. In this case, the patient had prior use of on NSAIDs without any documentation of significant improvement. There was no documentation of subjective or objective benefit from use of this medication. Medical necessity of the requested medication has not been established. The request for Relafen is not medically necessary.