

Case Number:	CM15-0211610		
Date Assigned:	10/30/2015	Date of Injury:	09/02/2014
Decision Date:	12/21/2015	UR Denial Date:	10/20/2015
Priority:	Standard	Application Received:	10/27/2015

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: California, District of Columbia, Maryland
 Certification(s)/Specialty: Anesthesiology, Pain Management

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 43 year old female who sustained an industrial injury on 09-02-2014. According to a progress report dated 09-17-2015, the injured worker reported 7 out of 10 low back pain with right lower extremity symptoms. Medications included Tramadol and Naproxen. Antiepileptic drugs had been tried and failed due to the side effects of lethargy and nausea. A trial of topical anti-epileptic drugs for neuropathic pain was successful. Objective findings included difficulty arising from seated position, favor of the left lower extremity with ambulation, nonantalgic gait, tenderness of the lumbar spine and lumboparaspinal musculature right greater than left with spasm, right sciatic notch tenderness, pain with lumbar range of motion, diminished sensation right L4, L5, S1 dermatomal distributions and positive straight leg raise at 45 degrees. Lower extremity neurologic evaluation demonstrated right quadriceps 4 plus out of 5, right inversion 5 minus out of 5, right EHL 4 plus out of 5, right eversion 4 plus out of 5. Diagnosis included protrusion 2 mm L4-5 and L5-S1 with neural encroachment L4 and L5. Lumbar myofascial component-trigger points remained refractory to extensive conservative treatment to date and involved trigger point injections, physical therapy, home exercise and activity modification. Medications prescribed included Hydrocodone, Naproxen and Cyclobenzaprine. Documentation shows use of Cyclobenzaprine dating back to 07-02-2015 and use of narcotic analgesia and Naproxen dating back to 06-04-2015. A urine toxicology report dated 05-14-2015 was submitted for review and showed inconsistent results for Butalbital, phenobarbital and secobarbital. On 10-20-2015, Utilization Review non-certified the request for

Hydrocodone 7.5 mg quantity 60, Naproxen 550 mg quantity 60 and Cyclobenzaprine 7.5 mg quantity 60.

IMR ISSUES, DECISIONS AND RATIONALES

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

Hydrocodone 7.5 mg Qty 60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids, specific drug list, Weaning of Medications.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids, criteria for use.

Decision rationale: Per MTUS Chronic Pain Medical Treatment Guidelines p78 regarding ongoing management of opioids "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 any 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." Review of the available medical records reveals no documentation to support the medical necessity of hydrocodone or any documentation addressing the "4 A's" domains, which is a recommended practice for the ongoing management of opioids. Specifically, the notes do not appropriately review and document pain relief, functional status improvement, appropriate medication use, or side effects. The MTUS considers this list of criteria for initiation and continuation of opioids in the context of efficacy required to substantiate medical necessity, and they do not appear to have been addressed by the treating physician in the documentation available for review. Efforts to rule out aberrant behavior (e.g. CURES report, UDS, opiate agreement) are necessary to assure safe usage and establish medical necessity. It was noted that UDS was obtained 9/17/15, however, results were not documented. As MTUS recommends discontinuing opioids if there is no overall improvement in function, the request is not medically necessary.

Naproxen 550 mg Qty 60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): NSAIDs (non-steroidal anti-inflammatory drugs), NSAIDs, GI symptoms & cardiovascular risk, NSAIDs, specific drug list & adverse effects.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): NSAIDs (non-steroidal anti-inflammatory drugs).

Decision rationale: With regard to the use of NSAIDs for chronic low back pain, the MTUS CPMTG states "Recommended as an option for short-term symptomatic relief. A Cochrane review of the literature on drug relief for low back pain (LBP) suggested that NSAIDs were no

more effective than other drugs such as acetaminophen, narcotic analgesics, and muscle relaxants. The review also found that NSAIDs had more adverse effects than placebo and acetaminophen but fewer effects than muscle relaxants and narcotic analgesics. In addition, evidence from the review suggested that no one NSAID, including COX-2 inhibitors, was clearly more effective than another." "Low back pain (chronic): Both acetaminophen and NSAIDs have been recommended as first line therapy for low back pain. There is insufficient evidence to recommend one medication over the other. Selection should be made on a case-by-case basis based on weighing efficacy vs. side effect profile." The documentation submitted for review indicates that the injured worker has been using this medication since at least 7/2015. As it is only recommended for short-term symptomatic relief, the request is not medically necessary.

Cyclobenzaprine 7.5 mg Qty 60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Muscle relaxants (for pain).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Muscle relaxants (for pain).

Decision rationale: With regard to muscle relaxants, the MTUS CPMTG 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." Regarding Cyclobenzaprine: "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." Per p41 of the MTUS guidelines, the effect is greatest in the first 4 days of treatment, suggesting that shorter courses may be better. Treatment is recommended for the treatment of acute spasm limited to a maximum of 2-3 weeks. UDS that evaluate for cyclobenzaprine can provide additional data on whether the injured worker is compliant, however in this case there is no UDS testing for cyclobenzaprine. The documentation submitted for review indicates that the injured worker has been using this medication since at least 9/2015. There is no documentation of the patient's specific functional level or percent improvement with treatment with cyclobenzaprine. As it is recommended only for short-term use, the request is not medically necessary.