

Case Number:	CM15-0036621		
Date Assigned:	03/05/2015	Date of Injury:	01/30/2012
Decision Date:	04/10/2015	UR Denial Date:	02/17/2015
Priority:	Standard	Application Received:	02/26/2015

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: District of Columbia, Virginia
Certification(s)/Specialty: Internal Medicine

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 48 year old male injured worker suffered an industrial injury on 1/30/2012. The diagnoses were cervical sprain/strain, left shoulder rotator cuff tear, right shoulder sprain/strain, sleep, psychiatric issues, and major depressive disorder. The diagnostic studies were cervical spine magnetic resonance imaging, electromyography. The treatments were left shoulder arthroscopy x 2 medications. The treating provider reported persistent neck pain 7/10. The left shoulder pain was 10/10 and constant. The pain is 5/10 with medications and 9/10 without medications. On exam there was decreased strength, tenderness and range of motion to the cervical spine and bilateral shoulder pain. The lumbar spine had reduced range of motion due to pain.

IMR ISSUES, DECISIONS AND RATIONALES

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

Flexeril 10 mg, ninety count: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 9792
Page(s): 64, 41-42.

Decision rationale: Per MTUS: 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). 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. It has a central mechanism of action but it is not effective in treating spasticity from cerebral palsy or spinal cord disease. Cyclobenzaprine is associated with a number needed to treat of 3 at 2 weeks for symptom improvement. The greatest effect appears to be in the first 4 days of treatment. (Browning, 2001) (Kinkade, 2007) (Toth, 2004) See Cyclobenzaprine. Cyclobenzaprine has been shown to produce a modest benefit in treatment of fibromyalgia. Cyclobenzaprine-treated patients with fibromyalgia were 3 times more likely to report overall improvement and to report moderate reductions in individual symptoms (particularly sleep). A meta-analysis concluded that the number needed to treat for patients with fibromyalgia was 4.8. (ICSI, 2007) (Tofferi, 2004) Side Effects: Include anticholinergic effects (drowsiness, urinary retention and dry mouth). Sedative effects may limit use. Headache has been noted. This medication should be avoided in patients with arrhythmias, heart block, heart failure and recent myocardial infarction. Side effects limit use in the elderly. (See, 2008) (Toth, 2004) Dosing: 5 mg three times a day; can be increased to 10 mg three times a day. This medication is not recommended to be used for longer than 2-3 weeks. (See, 2008) Cyclobenzaprine (Flexeril) recommended as an option, using a short course of therapy. See Medications for chronic pain for other preferred options. Cyclobenzaprine (Flexeril) is more effective than placebo in the management of back pain; the effect is modest and comes at the price of greater adverse effects. The effect is greatest in the first 4 days of treatment, suggesting that shorter courses may be better. (Browning, 2001) Treatment should be brief. There is also a post-op use. The addition of cyclobenzaprine to other agents is not recommended. (Clinical Pharmacology, 2008) Cyclobenzaprine-treated patients with fibromyalgia were 3 times as likely to report overall improvement and to report moderate reductions in individual symptoms, particularly sleep. (Tofferi, 2004) Note: Cyclobenzaprine is closely related to the tricyclic antidepressants, e.g., amitriptyline. See Antidepressants. Cyclobenzaprine is associated with a number needed to treat of 3 at 2 weeks for symptom improvement in LBP and is associated with drowsiness and dizziness. (Kinkade, 2007) Cyclobenzaprine is a skeletal muscle relaxant and a central nervous system (CNS) depressant that is marketed as Flexeril by Ortho McNeil Pharmaceutical. This medication would be indicated for short term usage, 2-3 weeks. It would not be indicated for long term usage.

Omeprazole 20 mg, thirty count: Overturned

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 9792 Page(s): 68.

Decision rationale: Per MTUS: NSAIDs, GI symptoms & cardiovascular risk recommend with precautions as indicated below. Clinicians should weight the indications for NSAIDs against

both GI and cardiovascular risk factors. Determine if the patient is at risk for gastrointestinal events: (1) age > 65 years; (2) history of peptic ulcer, GI bleeding or perforation; (3) concurrent use of ASA, corticosteroids, and/or anticoagulant; or (4) high dose/multiple NSAID (e.g., NSAID + low-dose ASA). Recent studies tend to show that H. Pylori does not act synergistically with NSAIDs to develop gastroduodenal lesions. Recommendations, Patients with no risk factor and no cardiovascular disease: Non-selective NSAIDs OK (e.g. ibuprofen, naproxen, etc.) Patients at intermediate risk for gastrointestinal events and no cardiovascular disease: (1) A non-selective NSAID with either a PPI (Proton Pump Inhibitor, for example, 20 mg omeprazole daily) or misoprostol (200g four times daily) or (2) a Cox-2 selective agent. Long-term PPI use (> 1 year) has been shown to increase the risk of hip fracture (adjusted odds ratio 1.44). Patients at high risk for gastrointestinal events with no cardiovascular disease: A Cox-2 selective agent plus a PPI if absolutely necessary. This patient had a history of gastric issues secondary to prior NSAID usage. This medication would be indicated.