

Case Number:	CM14-0176557		
Date Assigned:	10/29/2014	Date of Injury:	01/11/2013
Decision Date:	12/05/2014	UR Denial Date:	09/30/2014
Priority:	Standard	Application Received:	10/24/2014

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 Medicine and is licensed to practice in California. 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 57-year old assembler/machine operator reported a cumulative trauma injury on 1/11/13 as a result of repetitive heavy use of her hands. Originally the injury involved her hands and wrists, but her current treater has added other diagnoses. Treatment has included bilateral carpal tunnel releases. The patient has not worked since 2/18/13. Per an 8/26/14 progress note from her primary treater, the patient has worsening low back and leg pain, and pain and stiffness in her neck and upper back. Documented exam findings include tenderness and spasm of the neck and back; decreased range of motion of the right wrist, neck and back; with weakness of the right hand, bilateral foot dorsiflexors, ankle evertors, and knee extensors. Sensation is decrease bilaterally in an L3-S1 distribution. Diagnoses include cervical sprain with disc herniation; Lumbar sprain with disc herniation and right S1 radiculopathy; status post right carpal tunnel release; status post left carpal tunnel release with residuals; symptoms of anxiety/depression; and symptoms of insomnia. Treatment plan includes continued chiropractic treatment, lumbar spine epidural steroid injections, and refill of Anaprox 550 #120, "one tab twice daily, inflammation"; Fexmid 7.5 mg #120, one tab three times daily; Norco 10/325 mg #60, one tab every 12 hours, for pain; and Prilosec 20 mg #60, "once daily to prevent gastric mucosa". Work status is temporarily totally disabled (TTD). There are progress notes from the same provider in the records, dated 7/15/14 and 6/3/14, which document essentially the same complaints, findings and work status. No functional status other than the work status of TTD is documented in any of the notes. The record contains part of an AME evaluation performed 4/9/14, which documents that the patient was taking Naprosyn, cyclobenzaprine, tramadol and hydrocodone on that date. Of note is that the records contain the results of urine drug screens performed on 8/26/14 and 6/3/14 that are negative for hydrocodone, which should have been present if the patient had been taking

Norco as prescribed. The 8/26/14 requests for Anaprox and Fexmid were modified in UR on 9/30/14 to Anaprox 550 mg #60 and Fexmid 7.5.mg #30.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retrospective request for Anaprox 550 mg, QTY: 120 for the service date of 8/26/2014:

Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Medications for Chronic Pain; NSAIDs (non-steroidal anti-inflammatory drugs), Chronic low back p.

Decision rationale: Anaprox is brand-name naproxen, which is also known as Naprosyn (in a slightly different form). Anaprox is an NSAID. The MTUS guidelines cited above states that medications should be started individually while other treatments are held constant, with careful assessment of function. There should be functional improvement with each medication in order to continue it. The MTUS references regarding NSAIDs state that NSAIDs are recommended as an option for short-term symptomatic relief of chronic low back pain. A Cochrane review found that NSAIDs were no more effective than acetaminophen, narcotics or muscle relaxants; and that they were likely to have more side effects than acetaminophen and less side effects than narcotics or muscle relaxants. NSAIDs may be used to treat breakthrough and mixed pain conditions such as osteoarthritis with neuropathic pain, but there is only inconsistent evidence to support their use for long-term neuropathic pain. Clinicians should weight the indications for NSAIDs against both GI and cardiovascular risk factors. The medical findings in this case do not support the use of Anaprox 550 mg. This patient has been taking some form of naproxen for years. It is not clear whether it is being used for neuropathic pain or for low back pain, but there is no good evidence supporting long-term use of Anaprox for either condition. There is no documentation of any improvement in function while she has been taking it, and she remains totally disabled. There is no documentation of any flare of the patient's chronic pain which would require NSAID use. There is no documentation of the patient's cardiovascular or GI risk factors. She has both hypertension and hyperlipidemia, which puts her at risk for coronary artery disease, and NSAID use also, increases this risk. According to the evidence-based citations above and to the clinical documentation provided for my review, Anaprox 550 #120 is not medically indicated for this patient. Anaprox is not medically necessary because it is not likely to be helpful for treatment of long-term neuropathic or low back pain, because the patient's level of function has not improved while taking it, and because there is no documentation of GI risk factors or cardiovascular risk factors, and she in fact appears to be at risk for cardiovascular disease.

Retrospective request for Fexmid 7.5 mg, QTY: 120, for the service date of 8/26/2014:

Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Cyclobenzaprine (Flexeril).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Medications for Chronic Pain; Muscle relaxants Page(s): 60; 63-66.

Decision rationale: Fexmid is brand-name cyclobenzaprine, which is a sedating muscle relaxant. Per the first reference cited above, medications should be trialed one at a time while other treatments are held constant, with careful assessment of function, and there should be functional improvement with each medication in order to continue it. Per the second reference, non-sedating muscle relaxants are recommended with caution as a second-line option for short-term treatment of acute exacerbations in patients with chronic low back pain. In most low back pain patients, they show no benefit. There is no additional benefit if they are used in combination with NSAIDs. Efficacy appears to diminish over time. Cyclobenzaprine is only recommended for a short course of therapy, as there is no evidence to support its long-term use. Its greatest effect appears to occur within the first four days of treatment. Side effects include drowsiness, urinary retention, dry mouth and headaches. Its use should be avoided in patients with arrhythmias, heart block, heart failure and recent myocardial infarction. The clinical documentation in this case does not support the continued use of Fexmid. This patient has been on some form of cyclobenzaprine for years, and has exhibited no functional recovery. In addition, Fexmid is sedating and may be contributing to the patient's inactivity. Based on the MTUS citations above and on the clinical records provided for my review, Fexmid 7.5 mg #120 is not medically necessary in this case because there is no evidence to support its long-term use, because its use has not resulted in any functional recovery, and because its side effects may in fact make it more difficult for the patient to increase her level of activity.