

Case Number:	CM14-0215920		
Date Assigned:	01/06/2015	Date of Injury:	03/31/2009
Decision Date:	03/04/2015	UR Denial Date:	12/01/2014
Priority:	Standard	Application Received:	12/23/2014

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. 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: Colorado

Certification(s)/Specialty: Family Practice

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 female patient with an injury date of 03/31/2009. Supporting documentation described the worker having tripped, injuring her right shoulder, neck and lower back. She was noted to have undergone multiple treatment options including epidural steroid injections to the lumbar region with 3 months of positive effect. An MRI of the lumbar spine dated 11/20/2012 revealed degenerative changes with posterior element hypertrophy and grade I anterolisthesis as well as a broad posterior disc bulge protrusion. Per that same MRI, the central canal was noted to be mildly narrowed, lateral recesses narrowed and facet arthropathy noted at L5-S-1. She underwent another MRI on 11/28/2012 of cervical spine, which showed disc bulging at C3-4 through C6-7. Per the records, the patient has a history of methamphetamine and alcohol abuse and currently attends (REDACTED). The patient's (REDACTED) sponsor is holds the patient's medications and dispenses them at two day intervals, per the record. Per UR physician discussion with the treating physician 11/26/2014, current medications are naproxen, Nucynta, gabapentin, hydrocodone, omeprazole, amitriptyline, Motrin, and Norco, provide pain relief with 9/10 without medications and 4-8/10 with medications. (Elsewhere in the record it indicates patient discontinued Motrin in May 2014.) Physical examination documents the low back having 40 % range of motion with flexion and 60 % range of motion with extension. Straight leg raise is positive on the right side. She is diagnosed with sprain right rotator cuff, cervical disc degeneration, chronic pain syndrome, lumbar radiculitis, and degenerative disc disease. A retrospective request for services dated 11/21/2014 asks for medications Flexeril and Naproxen.

The Utilization Review denied the request on 12/01/2014 as not meeting medical necessity requirements.

IMR ISSUES, DECISIONS AND RATIONALES

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

Naproxen 550mg #60 dispensed 11/19/14: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Pain Interventions and Treatments Page(s): 22, and 67-68.

Decision rationale: Per the Guidelines, Non-steroidal anti-inflammatory drugs may be considered first-line therapy for short-term, symptomatic relief of moderate to severe pain, and recent clinical trials support the use in chronic low back as an effective measure. (Acetaminophen is considered first line therapy for mild to moderate pain or in patient's at high risk for adverse gastrointestinal events.) The non-steroidal anti-inflammatory drugs, though, do have more documented side effects and adverse events than Acetaminophen and fewer side effects than opioids and muscle relaxers. There is insufficient evidence to recommend one non-steroidal anti-inflammatory drug over another. Per the Guidelines, no consistent, quality evidence exists to support the use of Non-steroidal anti-inflammatory drugs in neuropathic pain, but some evidence suggests they may be useful in breakthrough pain, or combination pain syndromes (nociceptive pain with neuropathic pain). There is insufficient evidence to support long-term use of non-steroidal anti-inflammatory drugs for pain. As with other pain medications, assessment for improved pain and function should be documented when using non-steroidal anti-inflammatory drugs. For the patient of concern, the records indicate patient has been using Naproxen for more than 6 months for low back pain and neck pain with radiculopathy.

Furthermore, the record includes Motrin in the medication list as well in that same 6 months period, which is not ever recommended (2 non-steroidal anti-inflammatory drugs dosed at same time). The treating physician indicated in a phone call to the utilization reviewer that patient was indeed using both Motrin and Naproxen. Pain ratings are improved when Naproxen is included in patient regimen, but there is no objective assessment of function in relation to Naproxen. (Function is discussed as improved with patient pain medication regimen, but the records suggest that function is severely compromised when patient is out of her opioids, not her anti-inflammatory drug.) Without clear evidence that Naproxen improved pain as well as function and without confirmation that patient is NOT taking 2 non-steroidal anti-inflammatory drugs, the Naproxen is not medically indicated.

Flexeril 7.5mg #60 dispensed 11/19/14: Overturned

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

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

Decision rationale: Cyclobenzaprine, and other antispasmodics are recommended for musculoskeletal pain associated with spasm, but only for a short course. It has been shown to help more than placebo with back pain and fibromyalgia, but has several side effects that limit its use. Furthermore, Cyclobenzaprine works best in the first 4 days of use, so short courses recommended, no more than 2-3 weeks. No quality consistent evidence exists to support chronic use of Cyclobenzaprine. Common side effects of Cyclobenzaprine 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) For the patient of concern, the 11/19/2014 office visit indicates that patient is having a flare up of pain and new onset muscle spasms in neck and low back. Per the record, Flexeril has been requested for as needed use for the pain / spasm increase. As short term use for an acute flare up would be appropriate for Flexeril, and as the requested #60 tablets do not significantly exceed the recommendations for 3 weeks use, the request for Flexeril is medically indicated.