

<b>Case Number:</b>	CM15-0074215		
<b>Date Assigned:</b>	04/24/2015	<b>Date of Injury:</b>	01/31/2014
<b>Decision Date:</b>	05/21/2015	<b>UR Denial Date:</b>	03/18/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/18/2015

### 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: Iowa, Illinois, Hawaii

Certification(s)/Specialty: Preventive Medicine, Occupational Medicine, Public Health & General Preventive 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 injured worker is a 23-year-old female, who sustained an industrial injury on 1/31/14. She reported multiple related injuries over the past several years. The injured worker was diagnosed as having lumbar sprain/strain; multiple level disc protrusions. Treatment to date has included a transforaminal epidural steroid injection L3-L4 and L4-L5 (9/11/14); medications. Diagnostics testing include EMG/NCV lower extremities (8/19/14). Currently, the PR-2 notes dated 9/29/14 indicate the injured worker was "last seen on 8/9/14. A psyche evaluation and treat was recommended at the time. No authorization. Needs a refill of the meds. Second injection was given on 9/11/14 [transforaminal epidural steroid injection L3-L4 and L4-L5]. Helped for approximately two weeks. Third injection set for October. We will see her back in three to four weeks. Complaining of quite a bit of pain in the low back today approximately 7-8/10." Objective findings demonstrate dorsolumbar spine shows tenderness in lumbar paraspinal muscles with negative SLR, negative Fabere, no guarding and no deformities. There is restricted flexion to 70, extension 10, right and left bending 10 with motor strength 5/5. The provider requested Vicodin 5/300 mg #60/1 refill, Flexeril 10mg #30/1 refill, Ultram 50mg #60/1 refill and a follow-up with another provider and to return in 4 weeks. The medial documentation submitted is not the documentation presented at Utilization Review. The provider at that time requested Vicodin ES 7.5/300mg #60, Flexeril 10mg #30 with 1 refill and Voltaren gel 2-100g tubes with 1 refill.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Vicodin ES 7.5/300mg #60:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 78.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74-96. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low back, Opioids.

**Decision rationale:** Vicodin is the brand name version of hydrocodone and acetaminophen, which is considered a short-acting opioid. ODG does not recommend the use of opioids for shoulder pain "except for short use for severe cases, not to exceed 2 weeks." The patient has exceeded the 2 week recommended treatment length for opioid usage. MTUS does not discourage use of opioids past 2 weeks, but does state that "ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. Pain assessment should include: current pain; the least reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid; how long it takes for pain relief; and how long pain relief lasts. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life." While the treating physician does indicate a range of pain scale for the patient, it does not meet several of the prescribing guidelines, such as documenting intensity of pain after taking opioid, pain relief, increased level of function, improved quality of life, or other objective and functional outcomes, which is necessary for continued ongoing use of opioids. Additionally, this request is to increase the patient's current dosage of Vicodin, the treating physician has not provided rationale behind this request. As such, the request for Vicodin ES 7.5/300mg #60 is not medically necessary.

**Flexeril 10mg #30 with 1 refill:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 64.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Cyclobenzaprine, Medications for chronic pain, Antispasmodics Page(s): 41-42, 60-61, 64-66. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Cyclobenzaprine (Flexeril ½) and Other Medical Treatment Guidelines UpToDate, Flexeril.

**Decision rationale:** MTUS Chronic Pain Medical Treatment states for Cyclobenzaprine, "Recommended as an option, using a short course of therapy. The effect is greatest in the first 4 days of treatment, suggesting that shorter courses may be better. (Browning, 2001) Treatment should be brief." The medical documents indicate that patient is far in excess of the initial treatment window and period. Additionally, MTUS outlines that "Relief of pain with the use of medications is generally temporary, and measures of the lasting benefit from this modality should include evaluating the effect of pain relief in relationship to improvements in function and increased activity. Before prescribing any medication for pain the following should occur: (1)

determine the aim of use of the medication; (2) determine the potential benefits and adverse effects; (3) determine the patient's preference. Only one medication should be given at a time, and interventions that are active and passive should remain unchanged at the time of the medication change. A trial should be given for each individual medication. Analgesic medications should show effects within 1 to 3 days, and the analgesic effect of antidepressants should occur within 1 week. A record of pain and function with the medication should be recorded. (Mens, 2005)" Uptodate "flexeril" also recommends "Do not use longer than 2-3 weeks". Medical documents do not fully detail the components outlined in the guidelines above and do not establish the need for long term/chronic usage of cyclobenzaprine. ODG states regarding cyclobenzaprine, "Recommended as an option, using a short course of therapy. The addition of cyclobenzaprine to other agents is not recommended." The requested amount of Flexeril is in excess of the guideline recommendations. Additionally, the treating physician has not provided documentation of objective functional improvement with the use of this medication. As such, the request for Flexeril 10mg #30 with 1 refill is not medically necessary.

**Voltaren gel 2-100g tubes with 1 refill:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 112.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Compound creams.

**Decision rationale:** MTUS and ODG recommend usage of topical analgesics as an option, but also further details "primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed." The medical documents do not indicate failure of antidepressants or anticonvulsants. MTUS states, "There is little to no research to support the use of many of these agents. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended." MTUS specifically states for Voltaren Gel 1% (diclofenac) that it is "Indicated for relief of osteoarthritis pain in joints that lend themselves to topical treatment (ankle, elbow, foot, hand, knee, and wrist). It has not been evaluated for treatment of the spine, hip or shoulder." Medical records do not indicate that the patient is being treated for osteoarthritis pain in the joints. Additionally, the records indicate that the treatment area would be for lumbar spine. As such, the request for Voltaren gel 2-100g tubes with 1 refill is not medically necessary.