

Case Number:	CM13-0001164		
Date Assigned:	11/08/2013	Date of Injury:	10/20/2005
Decision Date:	07/09/2014	UR Denial Date:	07/01/2013
Priority:	Standard	Application Received:	07/10/2013

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 Physical Medicine & Rehabilitation has a subspecialty in Interventional Spine 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:

The patient is a 50-year-old male with a date of injury of 10/20/2005. The listed diagnoses per [REDACTED] are: lumbar radiculopathy status post lumbar fusion; postlaminectomy syndrome; cervical sprain/strain; chronic pain syndrome; chronic pain related insomnia; left hip sprain/strain; neuropathic pain; and lumbar facet syndrome. According to report dated 06/21/2013 by [REDACTED]. The patient presents with chronic low back pain. The patient has not received his prescription for Butran patch or Norco and this has caused an increase in pain and decrease in function. The patient's pain is 9/10 right now and with medication is 6-7/10, and without medication is 9/10. The report states regarding the use of Butran and Norco, these medications gives the patient pain control and greatly improved function as well as improvement in his mood. The patient is noted to be calmer and happier with both these medications. There are no adverse effects with taking the medications. A UDS is performed at each visit and they have been consistent with the prescribed medication. Treater is requesting a urine drug screen to assess compliance and refill of Norco, Zanaflex, Benadryl, Sintralyne, and Medrox patches.

IMR ISSUES, DECISIONS AND RATIONALES

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

URINE DRUG SCREEN: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids (steps to avoid misuse and addiction). Decision based on Non-MTUS Citation

University of Michigan Health System Guidelines for Clinical Care: Managing Chronic Non-terminal Pain, Including Prescribing Controlled Substances, pg. 33.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Drug Testing Page(s): 43. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Urine Drug Screen.

Decision rationale: This patient presents with chronic low back pain. The treating physician is requesting a drug screen to assess medication complaints and identify possible drug diversion. While MTUS Guidelines do not specifically address how frequent urine drug screenings should be obtained for various risks of opiate users, ODG provide clear recommendation. The ODG recommends once yearly urine drug following initial screening with the first 6 months for management of chronic opiate use in low risk patients. The report from 06/21/2013 indicates the patient has been administered monthly urine drug screens that have been consistent with the medications prescribed. In this case, a drug screen is not necessary, since the injured worker has had consistent results in the past. ODG Guidelines states once yearly is recommended for low risk patients. Therefore, the requested urine drug screen is not medically necessary.

NORCO 10/325MG, #120: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 60-89.

Decision rationale: This patient presents with chronic low back pain. The treating physician is requesting a refill of Norco 10/325 mg #120 for breakthrough pain. The MTUS Guidelines state that for initiating opioids recommends that reasonable alternative have been tried, consider patient's likelihood of improvement, likelihood of abuse, etc. The Guidelines further state that baseline pain and functional assessments should be made once the criteria have been met a new course of opioids may be tried at that time. The medical file provided for review includes one progress report. This report does not provide any discussion regarding medication efficacy and how it is impacting the patient's pain and function. There are no discussion regarding "pain assessment." Therefore, the requested Norco is not medically necessary.

ZANAFLEX 4MG, #90: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antispasticity/Antispasmodic Drugs Page(s): 66.

Decision rationale: This patient presents with chronic low back pain. The treating physicain is requesting a refill of Zanaflex 4 mg #90 3 times per day for muscle spasms. MTUS Guidelines

allow for the use of Zanaflex for low back pain, myofascial pain, and fibromyalgia. The guidelines require documentation of pain and function when medications are used for chronic pain. The medical file provided for review contains one progress report. This report requests a refill of Zanaflex, but does not provide any documentation as to how the patient is responding to Zanaflex. Given the patient's chronic back pain, Zanaflex may be indicated however there is no documentation on how this medication is making an impact on pain and function. Therefore, the requested Zanaflex is not medically necessary.

BENADRYL 25MG, #60: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Pain (Chronic).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Diphenhydramine.

Decision rationale: This patient presents with chronic low back pain. The treating physician is requesting a refill of Benadryl 25 mg #60 for insomnia. In regards to Benadryl, ODG state that sedating antihistamines are not recommended for long-term insomnia treatment. ODG states that for insomnia sedating antihistamines have been suggested for sleep aids (for example, diphenhydramine (Benadryl, OTC in U.S.). However, tolerance seems to develop within a few days. Next-day sedation has been noted as well as impaired psychomotor and cognitive function. Long-term use of Benadryl is not well established per the ODG. Therefore, the requested Benadryl is not medically necessary.

SINTRALYNE: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation www.pnarx.com by Pharmaceutica North America, Inc and the Official Disability Guidelines.

Decision rationale: The ACOEM, MTUS, and ODG guidelines do not discuss Sintralyne PM. However, an article on www.pnarx.com by [REDACTED] reports that Sintralyne PM is a supplement including Melatonin, Gamma-aminobutyric acid (GABA), and a proprietary blend of natural herbs and amino acids that aids patients in falling asleep. The article further states, it is used to treat insomnia, poor sleep quality and problems staying asleep. Although none of the guidelines specifically discuss this supplement. ODG does discuss one of the key ingredients in the supplement under the pain chapter. Under the discussion of medical foods, the ODG has the following regarding; GABA: This supplement is indicated for epilepsy, spasticity, and tardive dyskinesia. There is no high quality peer-reviewed literature that suggests that GABA is indicated for treatment of insomnia. Adverse reactions associated with treatment include hypertension, increased heart rate, and anxiety. In this case, a key ingredient in this supplement is not support by ODG for the treatment of insomnia. In addition, GABA is indicated

for epilepsy, spasticity and tardive dyskinesia, none of which this patient is being treated for. Therefore, the requested Sintralyne PM is not medically necessary.

MEDROX PATCH #30: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Creams Page(s): 111.

Decision rationale: This patient presents with chronic low back pain. The treating physician is requesting that the patient continue Medrox patches topically for muscle pain and stiffness. The MTUS, ACOEM, and ODG Guidelines do not discuss Medrox patches specifically. The MTUS Guidelines do discuss topical agents and state that it is largely experimental in which few randomized control trials to determine efficacy or safety, any compounded product that contains at least one drug or drug class that is not recommended is not recommended. In addition, Medrox is a compound topical analgesic including methyl salicylate 20%, menthol 7%, and capsaicin 0.050%. The guidelines allow capsaicin for chronic pain condition such as fibromyalgia, osteoarthritis, and nonspecific low back pain. However, the guidelines consider doses that are higher than 0.025% to be experimental particularly in high dosages of capsaicin. Medrox contains 0.050% of capsaicin, which is not supported in the MTUS Guidelines. Therefore, the requested Medrox patches are not medically necessary.