

<b>Case Number:</b>	CM13-0031260		
<b>Date Assigned:</b>	12/04/2013	<b>Date of Injury:</b>	07/30/2002
<b>Decision Date:</b>	02/18/2014	<b>UR Denial Date:</b>	09/19/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/03/2013

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Anesthesiology and Pain Medicine and is licensed to practice in Florida. 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 physician 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 female who reported an injury on 07/30/2002. The patient is diagnosed with post-laminectomy syndrome, low back pain, lumbar radiculopathy, and chronic pain syndrome. The patient was recently evaluated on 11/26/2013. The patient reported on-going lower back pain with radiation to the bilateral lower extremities and weakness. The physical examination revealed loss of lumbar lordosis, moderately decreased range of motion in the lumbar spine, mild tenderness to palpation of the lumbar paraspinal muscles, diffuse lower extremity muscle weakness, and decreased sensation along the lateral calf and lateral aspect of the foot bilaterally. Treatment recommendations included continuation of current medication including Xanax, Cymbalta, gabapentin, Percocet, fentanyl, Zanaflex, and ibuprofen.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Xanax 0.5mg tablet, as needed:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines Page(s): 24.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines benzodiazepines Page(s): 24.

**Decision rationale:** The Chronic Pain Guidelines indicate that benzodiazepines are not recommended for long-term use, because long-term efficacy is unproven and there is a risk of dependence. Most Guidelines limit the use for four (4) weeks. As per the clinical notes submitted, the patient has continuously utilized this medication. There is no documentation of anxiety or depressive symptoms. Despite the on-going use, there is no indication of functional improvement. As the guidelines do not recommend long-term use of this medication, the current request cannot be determined as medically appropriate. Additionally, the Chronic Pain Guidelines recommend antidepressants as a more appropriate treatment for anxiety disorder. Based on the clinical information received, the request for Xanax tablet, 0.5mg, as needed is non-certified.

**Cymbalta delayed release, 60 plus 30mg, one (1) capsule daily:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Specific Antidepressants Page(s): 15-16.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressants for chronic pain Page(s): 13-16.

**Decision rationale:** The Chronic Pain Guidelines indicate that antidepressants are recommended as a first-line option for neuropathic pain, and as a possibility for non-neuropathic pain. Cymbalta is FDA approved for anxiety, depression, diabetic neuropathy, and fibromyalgia. It has been used off label for neuropathic pain and radiculopathy. The patient has continuously utilized this medication. Despite on-going use, the patient continues to report lower back pain with bilateral lower extremity radiation and weakness. The patient continues to demonstrate decreased range of motion, diffuse muscle weakness, and decreased sensation. Satisfactory response to treatment has not been indicated by an increase in function, decrease in pain level, and change in the use of other analgesic medication, or sleep quality and duration. Based on the clinical information received, the request for Cymbalta delayed release, 60 plus 30mg, one (1) capsule daily is non-certified.

**Gabapentin 300mg, two (2) capsules three (3) times a day:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Specific Anti-epilepsy drugs Page(s): 18-19.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Antiepilepsy drugs (AEDs) Page(s): 16-18.

**Decision rationale:** The Chronic Pain Guidelines indicate that anti-epilepsy drugs are recommended for neuropathic pain. Gabapentin has been shown to be effective for treatment of diabetic painful neuropathy and postherpetic neuralgia, and has been considered a first-line treatment for neuropathic pain. The patient has continuously utilized this medication. Despite on-going use, the patient continues to report lower back pain with bilateral lower extremity radiation and weakness. The patient's physical examination does not reveal any significant

change that would indicate functional improvement. Based on the clinical information received, the request for Gabapentin 300mg, two (2) capsules three (3) times a day is non-certified.

**Percocet 10/325mg tablet, every six (6) hours:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Oxycodone/acetaminophen (Percocet; generic available). Page(s): 92.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74-82.

**Decision rationale:** The Chronic Pain Guidelines indicate that a therapeutic trial of opioids should not be employed until the patient has failed a trial of non-opioid analgesics. Baseline pain and functional assessments should be made. On-going review and documentation of pain relief, functional status, appropriate medication use, and side effects should occur. As per the clinical notes submitted, the patient has continuously utilized this medication. Despite on-going use, the patient continues to report persistent pain with radiation to bilateral lower extremities and weakness. There is no significant change in the patient's physical examination that would indicate functional improvement. Satisfactory response to treatment has not been indicated by a decrease in pain level, increase in function, or improved quality of life. Therefore, the on-going use cannot be determined as medically appropriate. As such, the request for Percocet 10/325mg tablet, every six (6) hours is non-certified.

**Fentanyl film, extended release, 50mcg per hour, one (1) patch applied on the skin, every seventy-two (72) hours:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, specific drug list, Antispasticity/Antispasmodic drugs Pa.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74-82.

**Decision rationale:** The Chronic Pain Guidelines indicate that a therapeutic trial of opioids should not be employed until the patient has failed a trial of non-opioid analgesics. Baseline pain and functional assessments should be made. On-going review and documentation of pain relief, functional status, appropriate medication use, and side effects should occur. As per the clinical notes submitted, the patient has continuously utilized this medication. Despite on-going use, the patient continues to report persistent pain with radiation to bilateral lower extremities and weakness. There is no significant change in the patient's physical examination that would indicate functional improvement. Satisfactory response to treatment has not been indicated by a decrease in pain level, increase in function, or improved quality of life. Therefore, the on-going use cannot be determined as medically appropriate. As such, the request for Fentanyl film, extended release, 50mcg per hour, one (1) patch applied on the skin, every seventy-two (72) hours is non-certified.

**Zanaflex 4mg, one (1) capsule, every six (6) hours:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Antispasticity/Antispasmodic drugs Page(s): 66.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain), Page(s): 63-66.

**Decision rationale:** The Chronic Pain Guidelines indicate that muscle relaxants are recommended as non-sedating second line options for short-term treatment of acute exacerbations in patients with chronic low back pain. Efficacy appears to diminish over time and prolonged use may lead to dependence. As per the clinical notes submitted, the patient has continuously utilized this medication. There is no documentation of palpable muscle spasm, spasticity, or muscle tension upon physical examination. Despite on-going use, the patient continues to report persistent pain with lower extremity radiation and weakness. As the guidelines do not recommend long-term use of this medication, the current request for Zanaflex 4mg, one (1) capsule, every six (6) hours is non-certified.

**Ibuprofen 800mg tablet, three (3) times a day: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): 72.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs (non-steroidal anti-inflammatory drugs) Page(s): 67-72.

**Decision rationale:** The Chronic Pain Guidelines indicate that NSAIDs are recommended for osteoarthritis at the lowest dose for the shortest period in patients with moderate to severe pain. Acetaminophen may be considered an initial therapy for patients with mild to moderate pain. The patient has continuously utilized this medication. Despite on-going use, the patient continues to report persistent pain. Satisfactory response to treatment has not been indicated. As the guidelines do not recommend long-term use of NSAID medication, the current request cannot be determined as medically appropriate. Therefore, the request for Ibuprofen 800mg tablet, three (3) times a day is non-certified.