

Case Number:	CM13-0047026		
Date Assigned:	12/27/2013	Date of Injury:	12/28/2006
Decision Date:	03/11/2014	UR Denial Date:	10/25/2013
Priority:	Standard	Application Received:	11/04/2013

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 Physical Medicine and Rehabilitation, has a subspecialty in Pain Management 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 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 51 year old male with a date of injury of 12/28/2006. The listed diagnoses per [REDACTED] dated 03/27/2013 are: 1. Failed back surgery syndrome 2. Status post hardware removal 3. History of multiple lumbar surgeries According to report dated 03/27/2013 by [REDACTED], patient presents with chronic right sided lower back pain that is mechanical and radicular in nature. The patient reports ongoing pain across the lower back. He continues to have weakness in both legs. Patient is status post hardware removal five months ago with continued low back pain. Examination showed weakness in his left leg across S1 distribution. His motor strength is otherwise intact. Treater requests refill on medications Clonazepam, Hydrocodone, Tizanidine, Gabapentin. AME report dated 07/19/2013 by [REDACTED] document that this patient has been under the care of [REDACTED] since 12/21/2011. Patient continues to follow up with [REDACTED] and "receives medications on a monthly basis." The report goes on to state patient "has had complications with medication dependence issues and this will have to be carefully monitored."

IMR ISSUES, DECISIONS AND RATIONALES

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

Clonazepam 1mg #60: Upheld

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

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

Decision rationale: This patient presents with chronic right sided lower back pain "that is mechanical and radicular in nature." Treater is requesting Clonazepam 1mg #60. MTUS page 24 states, "Benzodiazepines are not recommended for long-term use because long-term efficacy is unproven and there is a risk of dependence. Most guidelines limit use to 4 weeks. Their range of action includes sedative/hypnotic, anxiolytic, anticonvulsant, and muscle relaxant. Chronic benzodiazepines are the treatment of choice in very few conditions. Tolerance to hypnotic effects develops rapidly. Tolerance to anxiolytic effects occurs within months and long-term use may actually increase anxiety. A more appropriate treatment for anxiety disorder is an antidepressant. Tolerance to anticonvulsant and muscle relaxant effects occurs within weeks." MTUS guidelines are very clear on long term use of Benzodiazepines and recommends maximum use of 4 weeks due to "unproven efficacy and risk of dependence." Recommendation is for denial.

Hydrocodone APAP 10-325mg #180: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 88-89.

Decision rationale: This patient presents with chronic right sided lower back pain "that is mechanical and radicular in nature." Treater is requesting Hydrocodone APAP 10/325mg #180. For chronic opiates use MTUS guidelines (MTUS pgs 88, 89) require functioning documentation using a numerical scale or a validated instrument at least once every 6 months. Documentation of the four A's (Analgesia, ADL's, Adverse side-effects, Adverse behavior) are required. Furthermore, under outcome measures, it also recommends documentation of current pain; average pain; least pain; time it takes for medication to work; duration of pain relief with medications, etc. None of the 7 reports provided for review contain sufficient documentation demonstrating efficacy from chronic opiate use. None of the reports address potential dependence issue raised by one of the treaters. The patient should be slowly weaned as outlined in MTUS guidelines. Recommendation is for denial.

Tizanidine 4mg #90: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Zanaflex.

Decision rationale: This patient presents with chronic right sided lower back pain "that is mechanical and radicular in nature." Treater is requesting Tizanidine 4mg #90. For muscle relaxants, the MTUS guidelines pg 63 states "Recommend non-sedating muscle relaxants with

caution as a second-line option for short-term treatment of acute exacerbations in patients with chronic LBP." MTUS also has the following on "ANTISPASTICITY/ANTISPASMODIC DRUGS: (MTUS pg 66) Tizanidine (Zanaflex® , generic available) is a centrally acting alpha2-adrenergic agonist that is FDA approved for management of spasticity; unlabeled use for low back pain. (Malanga, 2008) Eight studies have demonstrated efficacy for low back pain." The treater does not discuss the efficacy of this medication. Recommendation is for denial.

Gabapentin 60mg #90: Overturned

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Gabapentin Page(s): 18-19.

Decision rationale: This patient presents with chronic right sided lower back pain "that is mechanical and radicular in nature." Treater is requesting Gabapentin 60mg #90. Utilization review dated 10/25/2013 denied request stating "there is no documentation as to presence of radicular pain." The MTUS guidelines have the following regarding Gabapentin (MTUS pg 18, 19). "Gabapentin (Neurontin®, Gabarone®, generic available) has been shown to be effective for treatment of diabetic painful neuropathy and posttherapeutic neuralgia and has been considered as a first-line treatment for neuropathic pain." AME report dated 07/19/2013 notes that patient has "residual lumbar radiculopathy" with positive straight leg raise and numbness, tingling and weakness of the lower bilateral extremities. In this case, Gabapentin is medically necessary and recommendation is for approval.