

Case Number:	CM13-0072632		
Date Assigned:	01/08/2014	Date of Injury:	01/28/2002
Decision Date:	04/22/2014	UR Denial Date:	12/19/2013
Priority:	Standard	Application Received:	12/31/2013

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 Internal Medicine and Emergency 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 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:

This patient is a 51 year-old with a date of injury of 01/28/02. A progress report associated with the request for services, dated 10/16/13, identified subjective complaints of pain in the back with bilateral numbness and tingling and bilateral shoulder pain. She also had constipation. Objective findings included tenderness to palpation of the lumbar spine with decreased sensation in multiple dermatomes of the right lower extremity. There was also decreased motor function on the right compared to the left. Diagnoses included chronic pain syndrome; opioid dependence; and degenerative spine disease. There was no documentation for a neuropathic component to her pain. Treatment has included multiple rhizotomies as well as opioid analgesics more than several months. A Utilization Review determination was rendered on 12/19/13 recommending non-certification of "Zanaflex #60; Senokot #60; Percocet #150; Lidoderm Patches 5% #30, 2 boxes".

IMR ISSUES, DECISIONS AND RATIONALES

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

ZANAFLEX #60: Overturned

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants Page(s): 63-66. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back, Muscle Relaxants

Decision rationale: Tizanidine (Zanaflex) is a centrally acting alpha2-adrenergic agonist antispasticity/antispasmodic muscle relaxant. Dosage recommended is 2-4 mg every eight hours up to a maximum of 36 mg per day. The Medical Treatment Utilization Schedule (MTUS) states that muscle relaxants are recommended with caution as a second-line option for short-term treatment of acute exacerbations of low back pain. However, eight studies have shown efficacy of tizanidine for low back pain (Chou 2007). The Official Disability Guidelines (ODG) also state that muscle relaxants are commonly used for treatment of low back problems. They also note that skeletal muscle spasm is not universally accepted as a cause of symptoms, and the most commonly used muscle relaxants have no peripheral effect on muscle spasm. The record states that the claimant's pain is reduced with her medications. The original denial of services was based upon the recommendation for short-term use muscle relaxants, but does not document functional improvement. There is stronger evidence for treatment of low back pain with Zanaflex than other muscle relaxants. Likewise, there is documentation of functional improvement. Therefore, in this case, there is documented medical necessity for Zanaflex.

SENOKOT #60: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Veterans Health Administration, Department of Defense

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 77. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Opioid-Induced Constipation Treatment

Decision rationale: The Medical Treatment Utilization Schedule (MTUS) and the Official Disability Guidelines (ODG) recommend prophylactic treatment of constipation with the initiation of opioids. The original non-certification was partially approved. Therefore, with the long-term use of opioids and ongoing constipation in this patient, there is documented medical necessity for docusate.

PERCOCET #150: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 308, Chronic Pain Treatment Guidelines Opioids Page(s): 74-83.

Decision rationale: Percocet is a combination of the opioid oxycodone and acetaminophen. The California Medical Treatment Utilization Schedule (MTUS) Guidelines related to on-going treatment of opioids state that there should be documentation and ongoing review of pain relief,

functional status, appropriate 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. A recent epidemiologic study found that opioid treatment for chronic non-malignant pain did not seem to fulfill any of the key outcome goals including pain relief, improved quality of life, and/or improved functional capacity (Eriksen 2006). The documentation submitted lacked a number of the elements listed above, including the level of functional improvement afforded by the chronic opioid therapy. The Guidelines also state that with chronic low back pain, opioid therapy "Appears to be efficacious but limited for short-term pain relief, and long-term efficacy is unclear (> 16 weeks), but also appears limited." Additionally, "There is also no evidence that opioids showed long-term benefit or improvement in function when used as treatment for chronic back pain (Martell - Annals, 2007)." The MTUS Guidelines further state that opioid therapy is not recommended for the low back beyond 2 weeks. The patient has been on opioids well in excess of 16 weeks. In this case, though there is no description of functional improvement from the medication, a diagnosis of opioid dependence, and no documentation of the other elements of the pain assessment referenced above for necessity of therapy beyond 16 weeks, where the evidence is otherwise unclear. Therefore, there is no documented medical necessity for Percocet.

LIDODERM PATCHES 5% #30, 2 BOXES: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Lidoderm (lidocaine patch) Page(s): 56-57. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chronic Pain, Lidoderm

Decision rationale: Lidoderm (lidocaine patch) is a topical anesthetic. The Medical Treatment Utilization Schedule (MTUS) states: "Topical lidocaine may be recommended for localized peripheral pain after there has been evidence of a trial of first-line therapy (tricyclic or SNRI antidepressants or an anti-epilepsy drug such as gabapentin or Lyrica). This is not a first-line treatment and is only FDA approved for post-herpetic neuralgia." The Official Disability Guidelines (ODG) also state that Lidoderm is not recommended until after a trial of first-line therapy. The following criteria are listed for use: *i*₁ · Recommended for a trial if there is evidence of localized pain that is consistent with a neuropathic etiology; *i*₂ · There should be evidence of a trial of first-line neuropathy medications (tricyclic or SNRI antidepressants or an AED such as gabapentin or Lyrica); *i*₃ · This medication is not generally recommended for treatment of osteoarthritis or treatment of myofascial pain/trigger joints; *i*₄ · An attempt to determine a neuropathic component of pain should be made; *i*₅ · The area for treatment should be designated as well as number of planned patches and duration of use (number of hours per day); *i*₆ · A trial of patch treatment is recommended for a short-term period; *i*₇ · Continued outcomes should be intermittently measured and if improvement does not continue, lidocaine patches should be discontinued. In this case, there is no documentation of the neuropathic component of the pain or complete trial of first-line agents. Therefore, there is no documented medical necessity of Lidoderm.

