

<b>Case Number:</b>	CM14-0102263		
<b>Date Assigned:</b>	09/16/2014	<b>Date of Injury:</b>	06/07/2003
<b>Decision Date:</b>	10/15/2014	<b>UR Denial Date:</b>	06/09/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/02/2014

### 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 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 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 injured worker is a 62-year-old male who sustained an injury on 6/7/03. He complained of low back pain radiating to the lower extremities. He is status post L4/L5 pedicle screw fixation and interbody fixation. He has chronic low back pain and lower extremity pain. Examination revealed decreased sensation over the left L5 distribution and strength was 4/5 in the lower extremities. There was positive straight leg raise which produced low back pain bilaterally. He underwent an extensive conservative treatment. Magnetic resonance imaging scan of the lumbar spine with gadolinium on 06/01/14 revealed postoperative changes at L4-5 level, mild degenerative changes developed at contiguous L3-4 levels, minor appearing right foraminal disc protrusion, and L3 nerve root impingement. His symptoms have required the use of continued narcotic pain medications as well as Lyrica for lower extremity symptoms. Diagnosis includes lumbosacral neuritis. The request for Norco 10/325 mg, one tablet every 6 hours as needed #40, Fentanyl patch 75 mcg, change every 72 hours #2 boxes, Zanaflex 4mg, one tablet by mouth three times a day as needed #90, and Lyrica 75 mg, one tablet by mouth three times a day #90 was denied on 06/09/14.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Norco 10/325 mg, one tablet Q6H PRN #40: 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): 75, 91.

**Decision rationale:** Norco (Hydrocodone + Acetaminophen) is indicated for moderate to severe pain. It is classified as a short-acting opioids, often used for intermittent or breakthrough pain. Guidelines indicate "four domains have been proposed as most relevant for ongoing monitoring of chronic pain workers on opioids; pain relief, side effects, physical and psychosocial functioning, and the occurrence of any potentially aberrant (or non-adherent) drug-related behaviors. These domains have been summarized as the "4 A's" (analgesia, activities of daily living, adverse side effects, and aberrant drug-taking behaviors)." There is no mention of ongoing attempts with non-pharmacologic means of pain management, such as home exercise program. There is little to no documentation of any significant improvement in pain level (i.e. visual analog scale) or function with continuous use to demonstrate the efficacy of this medication. There is no evidence of urine drug test in order to monitor compliance. Frequent dosing of short acting opioids is not recommended. There is no evidence of return to work. The medical documents do not support continuation of opioid pain management. Therefore, the medical necessity for Norco has not been established based on guidelines and lack of documentation.

**Fentanyl patch 75 mcg, change Q72H #2 boxes:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Specific Drug List Page(s): 93.

**Decision rationale:** Fentanyl transdermal (Duragesic; generic available): Indicated for management of persistent chronic pain, which is moderate to severe requiring continuous, around-the-clock opioid therapy. The pain cannot be managed by other means (e.g., nonsteroidal anti-inflammatory drugs). Duragesic should only be used in workers who are currently on opioid therapy for which tolerance has developed. Guidelines indicate "four domains have been proposed as most relevant for ongoing monitoring of chronic pain workers on opioids; pain relief, side effects, physical and psychosocial functioning, and the occurrence of any potentially aberrant (or non-adherent) drug-related behaviors. These domains have been summarized as the "4 A's" (analgesia, activities of daily living, adverse side effects, and aberrant drug-taking behaviors)." There is no mention of ongoing attempts with non-pharmacologic means of pain management, such as home exercise program. There is little to no documentation of any significant improvement in pain level (i.e. visual analog scale) or function with continuous use to demonstrate the efficacy of this medication. There is no evidence of urine drug test in order to monitor compliance. The medical documents do not support continuation of opioid pain management. Therefore, the medical necessity for Fentanyl patch has not been established based on guidelines and lack of documentation.

**Zanaflex 4mg, one tablet PO TID PRN #90:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants (For Pain) Page(s): 66.

**Decision rationale:** According to the Chronic Pain Medical Treatment Guidelines, Tizanidine "Zanaflex" is a centrally acting alpha2-adrenergic agonist that is Food and Drug Administration approved for management of spasticity; unlabeled use for low back pain. In this case, there is no diagnosis of spasticity. There is no documentation of any significant improvement in pain, spasm or function. Therefore, the request is not medically necessary according to the guidelines.

**Lyrica 75 mg, one tablet PO TID #90:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Antiepilepsy Drugs (AEDs).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Antiepilepsy Drugs (AEDs) Page(s): 19.

**Decision rationale:** As per Chronic Pain Medical Treatment Guidelines, Lyrica has been documented to be effective in treatment of diabetic neuropathy and postherpetic neuralgia, has Food and Drug Administration approval for both indications, and is considered first-line treatment for both. It is also Food and Drug Administration approved for treatment for generalized anxiety disorder and social anxiety disorder. There is no documentation that the injured worker has been diagnosed with diabetic neuropathy, postherpetic neuralgia, or anxiety disorder. Furthermore, there is no documentation of any significant improvement in pain (i.e. visual analog scale) or function with continuous use. Thus, the medical necessity has not been established and the request is not medically necessary and appropriate.