

Case Number:	CM14-0108980		
Date Assigned:	08/01/2014	Date of Injury:	11/15/2003
Decision Date:	09/25/2014	UR Denial Date:	07/07/2014
Priority:	Standard	Application Received:	07/14/2014

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 Neuromusculoskeletal Medicine and is licensed to practice in Arizona. 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 45-year-old female who sustained a work related injury on 11/15/2003 as result of falling backwards onto her tailbone causing injury to her right upper arm, neck and trunk. The patient has undergone a lumbar decompression and discectomy in 2003 and lumbar laminectomy surgery in 2008. Her most up to date medical documentation states she complains of bilateral lower back pain, worse right over left that radiates into her right hip and buttocks. She also has pain in her left neck with associated left arm numbness upon left rotation of the cervical spine. Her pain is 7/10 and typically wakes three times nightly because of pain. Her pain is worsened with activities, including house work. Her current pain management (Opana) reduces her pain to 3/10 and it is much better. On exam she has reduced lumbar range of motion (ROM), with a positive pelvic rock, sustained hip flexion with a negative straight leg raise bilaterally, palpatory tenderness in the lower lumbar area; worse on right, neurologically intact along lower extremities and without identified deficits. A lumbar MRI dated 01/19/2007 that identifies a right paracentral disk protrusion at L5-S1 and a very shallow central disk bulge at L4-5 and multilevel degenerative facet changes. An electromyography (EMG) obtained on 01/23/2007 found no evidence of right cervical radiculopathy, median or radial neuropathy; however, there is an isolated ulnar neuropathy, but only to one distally innervated muscle, exact location was not identified. The patient underwent a functional restoration program and detoxification in June of 2012. Her recent treatment regimen includes Opana ER 30mg, Cyclobenzaprine 10mg, Ibuprofen #60 and a Toradol injection. In dispute is a decision for Opana ER 30mg QTY: 60.00 and for Zanaflex 4mg (Retrospective dispensed on DOS 6/12/14).

IMR ISSUES, DECISIONS AND RATIONALES

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

Opana ER 30mg QTY: 60.00: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines, Opioids, Criteria for Use, page 80 and 93; Oxymorphone Extended Release (Opana ER).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Pain Intervention and Treatments Page(s): 79-80, 93.

Decision rationale: Oxymorphone (Opana), Oxymorphone Extended Release (Opana ER), no available generic: [Boxed Warnings]: Opana ER is not intended for as needed use. Patients are to avoid alcohol while on Opana ER due to increased (possibly fatal) plasma levels. Analgesic dose: (Immediate release) in opioid-naive patients the starting dose is 10- 20mg PO every 4 to 6 hours as needed. Patients may be started at doses of 5mg if appropriate (e.g., renal impairment). Note: It is not recommended to begin therapy at doses higher than 20mg due to adverse effects. (Extended release tablets) Opioid-naive patients should initially begin on 5m g every 12 hours around the clock. It is recommended that doses be individually titrated in increments of 5 to 10mg every 12 hours for 3 to 7 days. The discontinuance of opioids should occur if there is no overall improvement in function, evidence of intolerable adverse effects, a decrease in functioning, resolution of pain or series non-adherence is occurring. With regards to opioids for chronic pain management, in particular for chronic back pain, it appears to be efficacious but limited for short-term pain relief, and long- term efficacy is unclear (>16 weeks), but also appears limited. Failure to respond to a time limited course of opioids has led to the suggestion of reassessment and consideration of alternative therapy. There is no evidence to recommend one opioid over another. In patients taking opioids for back pain, the prevalence of lifetime substance use disorders has ranged from 36% to 56%.Of the submitted medical documentation, there is no evidence of other medicinal management attempted (Anti-depressants, anticonvulsants) to treat the patient's pain. I agree with the Utilization Reviewer that the patient has previously been diagnosed with chemical dependence and successfully underwent a detoxification program. This request is not medically necessary.

Zanaflex 4mg (Retrospective dispensed on DOS 6/12/14): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines, Muscle Relaxants (for pain), page 63 and page 66 Tizanidine (Zanaflex, generic available) Page(s): 63 & 66.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Pain Intervention and Treatments Page(s): 66.

Decision rationale: 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. One study (conducted only in females) demonstrated a significant decrease in pain associated with chronic myofascial pain syndrome and the authors recommended its use as a first

line option to treat myofascial pain. It may also provide benefit as an adjunct treatment for fibromyalgia. Aside from the fact that this medication use is off label for back pain, I agree with the Utilization Reviewer that the patient has previous been diagnosed with chemical dependence and successfully underwent a detoxification program. This request is not medically necessary.