

Case Number:	CM14-0137113		
Date Assigned:	09/05/2014	Date of Injury:	07/21/1995
Decision Date:	10/09/2014	UR Denial Date:	08/14/2014
Priority:	Standard	Application Received:	08/25/2014

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 Preventive Medicine 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:

According to the records made available for review, this is a 54-year-old male with a 7/21/95 date of injury. At the time (7/31/14) of request for authorization for Hytrin 5mg Cap 1 at bedtime # 30, Cyclobenzaprine 10mg tablet 1 TID prn (3 times a day as needed) # 90, Duragesic 25mg/hr patch 1 patch every 2 days # 30, and Norco 10/325mg #1120 1 q 4-6hrs PRN (1 each 4-6 hours as needed) for pain (max 5/day) # 120, there is documentation of subjective (sweating, back pain radiating to both legs, and right sided lumbar muscle spasms) and objective (antalgic gait, restricted range of motion of lumbar spine, tenderness to palpation over bilateral paravertebral muscles, tenderness to palpation over sacroiliac spine, and positive straight leg raise) findings, current diagnoses (cervical disc disorder, lumbar post laminectomy syndrome, spinal/lumbar degenerative disc disease, and lumbar radiculopathy), and treatment to date (medications (including ongoing treatment with (Hytrin, Lunesta, Cyclobenzaprine, Lyrica, Duragesic patch, and Norco since at least 3/6/14)). Medical report identifies documentation of an implanted opioid system. In addition, there is documentation of sweating as side effect from patient's chronic pain condition; that Duragesic patch used for baseline pain control; that with medications, pain is more tolerable, patient can complete simple house tasks, and able to walk 15-20 minutes on treadmill; and that a discussion regarding opioid medication was held with the patient, discussed the rules and regulations surrounding prescription of opioids and compliance, and that the risks and benefits of the medications prescribed for the patient were fully discussed. Regarding Hytrin, there is no documentation of a condition/diagnosis (with supportive subjective/objective findings) for which Hytrin is indicated (benign prostatic hyperplasia or hypertension). Regarding Cyclobenzaprine, there is no documentation of acute exacerbations of chronic low back pain, and intention to treat over a short course (less than two weeks). Regarding Duragesic patch, there is no documentation of persistent, moderate to severe chronic pain that requires continuous,

around-the-clock opioid administration for an extended period of time, and cannot be managed by other means; that the patient has demonstrated opioid tolerance, and requires a total daily dose at least equivalent to Duragesic 25 mcg/h; and no contraindications exist.

IMR ISSUES, DECISIONS AND RATIONALES

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

Hytrin 5mg Cap # 30: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation <http://www.drugs.com/hytrin.html>, <http://www.rxlist.com/hytrin-drug/indications-dosage.htm>, <http://www.ncbi.nlm.nih.gov/pubmed/22731399>

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Complex Regional Pain Syndrome (CRPS) Page(s): 38. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: <http://www.drugs.com/pro/terazosin.html>

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines identifies terazosin can be helpful in Sympathetically Mediated Pain. ODG does not address this issue. Medical treatment guideline identifies documentation of a condition/diagnosis (with supportive subjective/objective findings) for which Hytrin is indicated (such as: benign prostatic hyperplasia or hypertension). Within the medical information available for review, there is documentation of diagnoses of cervical disc disorder, lumbar post laminectomy syndrome, spinal/lumbar degenerative disc disease, and lumbar radiculopathy. However, despite documentation of a request for Hytrin for sweating as side effect from patient's chronic pain condition, there is no documentation of a condition/diagnosis (with supportive subjective/objective findings) for which Hytrin is indicated (benign prostatic hyperplasia or hypertension). Therefore, based on guidelines and a review of the evidence, the request for Hytrin 5mg Cap # 30 is not medically necessary and appropriate.

Cyclobenzaprine 10mg tablet # 90: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Cyclobenzaprine (Flexeril) Page(s): 41-42. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Muscle relaxants (for pain) Other Medical Treatment Guideline or Medical Evidence: Title 8, California Code of Regulations, section 9792.20

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines identifies that Flexeril is recommended for a short course of therapy. MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. ODG identifies that muscle relaxants are recommended as a

second line option for short-term (less than two weeks) treatment of acute low back pain and for short-term treatment of acute exacerbations in patients with chronic low back pain. Within the medical information available for review, there is documentation of diagnoses of cervical disc disorder, lumbar post laminectomy syndrome, spinal/lumbar degenerative disc disease, and lumbar radiculopathy. In addition, there is documentation of ongoing treatment with Cyclobenzaprine and Cyclobenzaprine used as a second line option. Furthermore, there is documentation of functional benefit and an increase in activity tolerance as a result of Cyclobenzaprine use to date. However, there is no documentation of acute muscle spasm or acute exacerbations of chronic low back pain. In addition, given documentation of records reflecting prescriptions for Flexeril since at least 3/6/14, there is no documentation of the intention to treat over a short course (less than two weeks). Therefore, based on guidelines and a review of the evidence, the request for Cyclobenzaprine 10mg tablet # 90 is not medically necessary and appropriate.

Duragesic 25mg/hr patch # 30: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Duragesic (fentanyl transdermal system) Page(s): 44. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Title 8, California Code of Regulations, section 9792.20; and FDA Official Disability Guidelines (ODG) Pain, Duragesic and Fentanyl

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines identifies documentation of chronic pain in patients who require continuous opioid analgesia for pain that cannot be managed by other means, as criteria necessary to support the medical necessity of Duragesic. MTUS Chronic Pain Medical Treatment Guidelines identifies that Duragesic is not recommended as first-line therapy. MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. ODG identifies documentation that Duragesic is not for use in routine musculoskeletal pain. FDA identifies documentation of persistent, moderate to severe chronic pain that requires continuous, around-the-clock opioid administration for an extended period of time, and cannot be managed by other means; that the patient is already receiving opioid therapy, has demonstrated opioid tolerance, and requires a total daily dose at least equivalent to Duragesic 25 mcg/h; and no contraindications exist, as criteria necessary to support the medical necessity of Duragesic patch. Within the medical information available for review, there is documentation of diagnoses of cervical disc disorder, lumbar post laminectomy syndrome, spinal/lumbar degenerative disc disease, and lumbar radiculopathy. In addition, there is documentation of ongoing treatment with Duragesic patch and that patient is already receiving opioid therapy (Norco). Furthermore, there is documentation of functional benefit and an increase in activity tolerance as a result of Duragesic patch use to date. However, despite documentation of pain, there is no documentation of persistent, moderate to severe chronic pain that requires continuous, around-the-clock opioid administration for an extended period of time, and cannot be managed by other means. In addition, there is no documentation that the patient

has demonstrated opioid tolerance, and requires a total daily dose at least equivalent to Duragesic 25 mcg/h; and no contraindications exist. Therefore, based on guidelines and a review of the evidence, the request for Duragesic 25mg/hr patch # 30 is not medically necessary and appropriate.

Norco 10/325mg # 120: Overturned

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74-80. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Title 8, California Code of Regulations, section 9792.20

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines necessitate documentation that the prescriptions are from a single practitioner and are taken as directed; the lowest possible dose is being prescribed; and there will be ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects, as criteria necessary to support the medical necessity of opioids. MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. Within the medical information available for review, there is documentation of diagnoses of cervical disc disorder, lumbar post laminectomy syndrome, spinal/lumbar degenerative disc disease, and lumbar radiculopathy. In addition, there is documentation of ongoing treatment with Norco. Furthermore, there is documentation that the prescriptions are from a single practitioner and are taken as directed; the lowest possible dose is being prescribed; and there will be ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. Lastly, there is documentation of functional benefit and an increase in activity tolerance as a result of Norco use to date. Therefore, based on guidelines and a review of the evidence, the request for Norco 10/325mg # 120 is medically necessary and appropriate.