MAXIMUS Federal Services

Case Number:	CM14-0051243		
Date Assigned:	08/08/2014	Date of Injury:	08/24/1999
Decision Date:	09/24/2014	UR Denial Date:	04/09/2014
Priority:	Standard	Application Received:	04/18/2014

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 Occupational 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:

Patient is a 58 year-old male with date of injury 08/24/1999. The medical document associated with the request for authorization, a primary treating physician's progress report, dated 02/19/2014, lists subjective complaints as pain in the low back which radiates down the left leg. Objective findings: Examination of the lumbar spine revealed loss of normal lordosis with straightening of the spine. Range of motion was restricted by pain with tenderness over the left sided sacroiliac joint. On palpation, tenderness was noted over the paravertebral muscles, spasm and tight muscle band was noted on the left side. Straight leg test was positive. Diagnosis: post lumbar laminectomy syndrome 2. Disc disorder lumbar 3. Chronic back pain. The medical records supplied for review document that the patient has been taking the following medication at least as far back as 1 year. Medications:1.Norco 10/325mg, #150 SIG: 6 per day 2.Duragesic 75mg/hr patch #10 SIG: 1 patch every 3 days 3.Tizanidine Tab 4mg SIG: 2 per day 4.Tiagabine Tab 4mg: no SIG given 5.Topiramate tab 100mg: no SIG given 6.Vanlafaxine Cap 75mg ER: no SIG given 7.Sertraline Tab 100mg: no SIG given Approximately two years prior to the time of the request for the above medications, the patient had undergone a Drug Utilization Peer Assessment dated 03/01/2012. The pharmacist who wrote the report expressed concern regarding each of the above medications. The prescribing physician was contacted and made aware of these concerns, as well as possible solutions for a safer, more effective drug regimen. According to the report, the prescribing physician would not commit to implement any of the recommended changes.

IMR ISSUES, DECISIONS AND RATIONALES

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

Norco 10/325mg # 150: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 74-94.

Decision rationale: The previous utilization review decision provided the patient with sufficient quantity of medication to be weaned slowly off of narcotic. The Chronic Pain Medical Treatment Guidelines state that continued or long-term use of opioids should be based on documented pain relief and functional improvement or improved quality of life. Despite the long-term use of narcotics, the patient has reported very little, if any, functional improvement or pain relief over the course of the last year. The request is not medically necessary.

Duragesic 75mcg/hr patch #10: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 74-94.

Decision rationale: The previous utilization review decision provided the patient with sufficient quantity of medication to be weaned slowly off of narcotic and asked that documentation be provided in the form of improvements in functional ability and they signed pain contract. The Chronic Pain Medical Treatment Guidelines state that continued or long-term use of opioids should be based on documented pain relief and functional improvement or improved quality of life. Despite the long-term use of narcotics, the patient has reported very little, if any, functional improvement or pain relief over the course of the last year and the above documentation was not provided. The request is not medically necessary.

Tiagabine Tab 4 mg: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 17.

Decision rationale: Tiagabine is an anti-convulsive medication produced by [redacted] and marketed under the brand name Gabitril. A "good" response to the use of AEDs has been defined as a 50% reduction in pain and a "moderate" response as a 30% reduction. It has been reported that a 30% reduction in pain is clinically important to patients and a lack of response of this magnitude may be the "trigger" for the following: (1) a switch to a different first-line agent

(TCA, SNRI or AED are considered first-line treatment); or (2) combination therapy if treatment with a single drug agent fails. After initiation of treatment there should be documentation of pain relief and improvement in function as well as documentation of side effects incurred with use. The continued use of AEDs depends on improved outcomes versus tolerability of adverse effects. There is no documentation of any of the above criteria and the patient is taking two AEDs. The request is not medically necessary.

Topiramate Tab 100mg: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines AED's. Decision based on Non-MTUS Citation Official Disability Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 17.

Decision rationale: Topiramate (brand name Topamax) is an anticonvulsant (antiepilepsy) drug. As stated above,As stated above, a "good" response to the use of AEDs has been defined as a 50% reduction in pain and a "moderate" response as a 30% reduction. It has been reported that a 30% reduction in pain is clinically important to patients and a lack of response of this magnitude may be the "trigger" for the following: (1) a switch to a different first-line agent (TCA, SNRI or AED are considered first-line treatment); or (2) combination therapy if treatment with a single drug agent fails. After initiation of treatment there should be documentation of pain relief and improvement in function as well as documentation of side effects incurred with use. The continued use of AEDs depends on improved outcomes versus tolerability of adverse effects. There is no documentation of any of the above criteria and the patient is taking two AEDs. The request is not medically necessary.

Tizanidine Tab 4mg: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants. Decision based on Non-MTUS Citation Official Disability Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 63.

Decision rationale: Tizanidine or Zanaflex is a drug that is used as a muscle relaxant. The MTUS states that muscle relaxants are recommended with caution only on a short-term basis. The patient has been taking the muscle relaxant for an extended period of time and tizanidine is no longer appropriate. The request is not medically necessary.

Vanlafaxine Cap 75mg ER: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain (Chronic), Venlafaxine (EffexorÂ®).

Decision rationale: The MTUS recommends Effexor as an option in first-line treatment of neuropathic pain. Venlafaxine (Effexor) is a member of the Selective serotonin and norepinephrine reuptake inhibitors (SNRIs) class of antidepressants. It has FDA approval for treatment of depression and anxiety disorders. It is off-label recommended for treatment of neuropathic pain, diabetic neuropathy, fibromyalgia, and headaches. This first-line SNRI can be recommended in the future to treat the patient's painful condition, however, the request contains no quantity of medication nor does it contained directions for administration; as such, is not medically necessary at this time.

Sertraline Tab 100mg: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 13.

Decision rationale: Sertraline (trade names Zoloft, Lustral) is an antidepressant of the selective serotonin reuptake inhibitor (SSRI) class. The MTUS recommends antidepressants as a first line option for neuropathic pain, and as a possibility for non-neuropathic pain, but tricyclics are generally considered a first-line agent unless they are ineffective, poorly tolerated, or contraindicated. There is no documentation in the medical record that tricyclics have been ineffective, poorly tolerated, or contraindicated. In addition, the request contains no quantity of medication nor does it contained directions for administration; as such, is not medically necessary at this time.