

Case Number:	CM14-0063846		
Date Assigned:	07/11/2014	Date of Injury:	08/11/2010
Decision Date:	08/08/2014	UR Denial Date:	04/16/2014
Priority:	Standard	Application Received:	05/06/2014

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 Anesthesiology, has a subspecialty 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:

According to the records made available for review, this is a 54-year-old male with a 8/11/10 date of injury, and status post left knee anterior cruciate ligament reconstruction and meniscectomy 5/4/12, and status post L4 to S1 anterior lumbar interbody fusion 8/27/12. At the time (4/16/14) of request for authorization for Duragesic 75 mcg/hr Patch #10, Ambien 10 mg tablet #20, and Zanaflex 4mg tablet #60, there is documentation of subjective (lower backache, bilateral shoulder pain, and abdominal pain) and objective (antalgic gait, restricted cervical and lumbar range of motion limited by pain, tenderness of paravertebral muscles, paracervical muscles, trapezius and over bilateral cervical facet joints, spinous process tenderness on C7, lumbar spasm, Gaenslen's positive, lumbar facet loading positive on both side, Faber positive findings, positive Hawkin's and Neer's test bilaterally, tenderness to palpation over lateral and medial joint line and patella bilaterally, and mild effusion in left knee), current diagnoses (post lumbar laminectomy syndrome, lumbar facet syndrome, cervical facet syndrome, cervical spondylosis, knee pain, spinal/lumbar degenerative disc disease, disc disorder cervical, sacroiliac pain, and radiculopathy), and treatment to date (medications (including ongoing treatment with Ambien (which helps him fall asleep) and Duragesic patch since at least 7/24/13, Zanaflex since at least 9/18/13, and Oxycodone with improvement in function and activities of daily living with medications)). Regarding Duragesic Patch, there is no documentation of pain that requires continuous, around-the-clock opioid administration for an extended period of time, cannot be managed by other means; has demonstrated opioid tolerance, and no contraindications exist. Regarding Ambien, there is no documentation of the intention to treat over a short course. Regarding Zanaflex, there is no documentation of acute muscle spasms and the intention to treat over a short course.

IMR ISSUES, DECISIONS AND RATIONALES

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

Duragesic 75 mcg/hr Patch #10: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Duragesic (fentanyl transdermal system) Page(s): 44. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Duragesic and Fentanyl and FDA.

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 post lumbar laminectomy syndrome, lumbar facet syndrome, cervical facet syndrome, cervical spondylosis, knee pain, spinal/lumbar degenerative disc disease, disc disorder cervical, sacroiliac pain, and radiculopathy. In addition, there is documentation of persistent, moderate to severe chronic pain; that the patient is already receiving opioid therapy, and requires a total daily dose at least equivalent to Duragesic 25 mcg/h. In addition, given documentation of improvement in function and activities of daily living with medications, there is documentation of functional benefit and improvement an increase in activity tolerance as a result of Duragesic Patch to date. However, there is no documentation of pain that requires continuous, around-the-clock opioid administration for an extended period of time, and cannot be managed by other means; has demonstrated opioid tolerance, and no contraindications exist. Therefore, based on guidelines and a review of the evidence, the request for Duragesic 75 mcg/hr Patch #10 is not medically necessary.

Ambien 10 mg tablet #20: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Chapter, Zolpidem.

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

Decision rationale: MTUS does not address this issue. 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 Ambien (zolpidem) as a prescription short-acting nonbenzodiazepine hypnotic, which is approved for the short-term (usually two to six weeks) treatment of insomnia. Within the medical information available for review, there is documentation of diagnoses of post lumbar laminectomy syndrome, lumbar facet syndrome, cervical facet syndrome, cervical spondylosis, knee pain, spinal/lumbar degenerative disc disease, disc disorder cervical, sacroiliac pain, and radiculopathy. In addition, there is documentation of insomnia. Furthermore, given documentation that Ambien helps patient fall asleep, there is documentation of functional benefit and improvement as a result of Ambien use to date. However, given documentation of records reflecting prescriptions for Zolpidem since at least 7/24/13, there is no documentation of the intention to treat over a short course (less than two to six weeks). Therefore, based on guidelines and a review of the evidence, the request for Ambien 10 mg tablet #20 is not medically necessary.

Zanaflex 4mg tablet #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants Page(s): 63.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antispasticity/Antispasmodic Drugs (Tizanidine (Zanaflex)) Page(s): 66. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Muscle relaxants (for pain).

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines identifies documentation of spasticity, as criteria necessary to support the medical necessity of Tizanidine. 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 post lumbar laminectomy syndrome, lumbar facet syndrome, cervical facet syndrome, cervical spondylosis, knee pain, spinal/lumbar degenerative disc disease, disc disorder cervical, sacroiliac pain, and radiculopathy. In addition, there is documentation of muscle spasms. Furthermore, given documentation of improvement in function and activities of daily living with medications, there is documentation of functional benefit and improvement an increase in activity tolerance as a result of Zanaflex to date.

However, given an 8/11/10 date of injury, there is no documentation of acute muscle spasms. In addition, given documentation of records reflecting prescriptions for Zanaflex since at least 9/18/13, 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 Zanaflex 4mg tablet #60 is not medically necessary.