MAXIMUS Federal Services

Case Number:	CM14-0085132		
Date Assigned:	07/23/2014	Date of Injury:	09/20/2000
Decision Date:	08/28/2014	UR Denial Date:	05/12/2014
Priority:	Standard	Application Received:	06/06/2014

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 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:

According to the records made available for review, this is a 51-year-old gentleman with a date of injury of 9/20/2000. Mechanism of injury was cumulative trauma. This is a request for Zanaflex, Ambien, Hydrocodone, Valium, and Subsys, which was prescribed on 4/21/14. Patient had subjective complaints of persistent pain in the low back constantly radiating down the legs to the feet. Standing and walking worsens the pain. Activities of daily living cause significant amount of pain and stiffness in the lumbar spine. Pain levels interfered with general activities of daily living 5-7/10, mood 1/10, normal work 2/10, sleep 8/10, enjoyment of life 5-6/10, inability to concentrate 2-3/10. Objectively, there is paraspinal muscle tenderness to palpation, decreased sensation to light touch in the lumbar spine, painful range of motion, left thigh numbness progressively getting worse, depressed mood and affect, and weight gain secondary to immobility. The subjective complaints were essentially unchanged from a 2/24/14 report. The discussion portion of both of those reports indicate that the patient states the pain is becoming worse and is increasing in severity. Diagnoses included discogenic low back pain, lumbar spondylosis, lumbar spine sprain/strain syndrome, thoracic spine sprain/strain syndrome, obesity secondary to immobilization as a result of injury, insomnia, depression, and anxiety. There was no mention of what type of work if any the patient was actually doing. There is no mention that the patient participated in any type of Home Exercise Program. It was felt that the patient would benefit from transforaminal epidural steroid injections left L4-5 and L5-S1. Other reports indicated the patient has failed conservative treatment including PT, chiropractic treatment, medications, rest, and a home exercise program. Patient was given a refill of Fentora, Hydrocodone, Valium, and Ambien. There was also previous treatment with multiple procedures including IDET, multiple epidural injections which gave no significant relief.

IMR ISSUES, DECISIONS AND RATIONALES

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

Zanaflex 40 mg # 90: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines part 2 Page(s): 63-66.

Decision rationale: MTUS Chronic Pain Guidelines state that this medication, also known as Tizanidine, is FDA approved for management of spasticity and unlabeled use for low back pain. It is a sedating antispasticity/antispasmodic drug. MTUS Chronic Pain Guidelines recommend the use of muscle relaxants as a 2nd line option for short-term treatment of acute exacerbations in patients with chronic low back pain. At the time that this was requested for refill, use had been chronic and there had not been any notation of any reduction in the patient's muscle spasms and patient's chronic pain was subjectively worsening. Thus, based upon guidelines and a review of the evidence, this is not considered to be medically necessary.

Ambien CR 12.5 mg: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines-Treatment in Worker's Compensation - Pain Procedure Summary; Mosby's Drug Consult.

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), Insomnia treatment and Zolpidem.

Decision rationale: Ambien is the brand name for the generic zolpidem. While MTUS guidelines are silent on this medication, ODG online guidelines note that this is approved for short-term, usually 2-6 weeks for treatment of insomnia. Ambien CR is approved for chronic use but chronic use of hypnotics in general is discouraged. Ambien CR has been shown to be effective 24 weeks in adults but in this case the patient's rating of his sleep ability did not improve and remained 8/10 despite at least 4 months of treatment with this medication. Therefore, based upon the evidence presented and the guidelines, continued use of the Ambien CR is not medically necessary.

Hydrocodone 20 mg # 180: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines part 2 Page(s): 74-96.

Decision rationale: The patient had been using the Hydrocodone chronically and complained that it did not give him much pain relief. It was continued to be prescribed. MTUS Chronic Pain Guidelines for ongoing management with opiates states the lowest possible dose should be prescribed to improve pain and function. MTUS Guidelines would not support continued use of the opiates when there is no overall improvement in function, which was not documented in the medical records provided. Therefore, based upon the guidelines and evidence available, this is not considered to be medically necessary.

Valium 2 mg # 10: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines part 2 Page(s): 24.

Decision rationale: None of the reports submitted indicate why the patient was being prescribed the Valium, which is also known as Diazepam. It is in the class of medications known as Benzodiazepines. MTUS guidelines state that long-term use greater than 4 weeks is not recommended because tolerance to hypnotic effects develops rapidly. If being prescribed for anxiety, tolerance to anxiolytic effects occurs within months. Since there is no indication of the rationale for what this is being prescribed for and since the medical reports do not document that this patient was having any improvement in function, continued use of this medication is not medically necessary based upon the guidelines and available evidence.

Subsys (Fentanyl Spray): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids. Decision based on Non-MTUS Citation Officialy Disability Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines part 2 Page(s): 74-96. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: subsysspray.com-manfactureers prescribing information.

Decision rationale: MTUS Guidelines do not address this particular formulation of Fentanyl which is a sublingual spray. MTUS guidelines do address Fentanyl, however, it is not supported for first-line analgesic use. Manufacturers prescribing information stated this is an opioid agonist indicated for the management of breakthrough pain in cancer patients already receiving and who are already tolerant to opioid therapy. Patients must remain on around-the-clock opiates while taking this medication. This patient is not a cancer patient. He is not prescribed any extended-release oral opiates, only short acting Hydrocodone. Furthermore, the requesting report states that the patient tried this medication and was happy with the results but at the same time there is complaint of increasing pain severity. Thus, based upon the evidence provided, guidelines, and FDA-approved use as reflected in the prescribing information, this is not considered to be medically necessary.