

Case Number:	CM14-0089485		
Date Assigned:	09/19/2014	Date of Injury:	04/27/2010
Decision Date:	10/24/2014	UR Denial Date:	05/23/2014
Priority:	Standard	Application Received:	06/13/2014

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 Tennessee. 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 59-year-old male who has submitted a claim for Postlaminectomy syndrome, lumbar region associated with an industrial injury date of April 27, 2010. Medical records from 2013 through 2014 were reviewed, which showed that the patient complained of low back pain, tightness and spasm. Pain was rated 5/10 with the use of medication and 10/10 without medications. With the use of opioids, the patient was able to get up and perform routine ADLs such as bathing, dressing and grooming. The patient was able to continue with an exercise program, which was mainly walking. Physical examination showed restricted ROM in all pains secondary to pain. He has weakness bilaterally and shows 4/5 strength with hip flexors and adductors. There was tenderness above the fusion construct at L2-3. MRI scan show T12 disc protrusion. Treatment to date has included surgery, opioids (since Dec 2013), intermittent NSAIDs and tizanidine (since at least February 2014). Utilization review from May 23, 2014 denied the request for Oxycodone 10mg per 05/09/14 QTY90, Zanaflex 2mg per 05/09/14 QTY:60, Naprosyn 550mg ,per 05/09/14 QTY:50, Omeprazole 20mg , per 05/09/14 QTY 60, and Lidoderm 5% patch , per 05/09/14 QTY: 30. The request for oxycodone was denied because there was no documentation that the prescriptions were from a single practitioner and were taken as directed and that the lowest possible dose was prescribed and there would be ongoing review and documentation of pain relief, functional status and appropriate medication use and side effects. The request for Zanaflex was denied because there is no documentation of spasms on exam and that patient had been taking the medication previously. The request for Naprosyn was denied because it was used for an unknown duration and it does not appear that there has been any derived benefit from its use. The request for omeprazole was denied because Naprosyn was denied and there wasn't the risk for GI event. The request for Lidoderm 5% patch was denied

because there is no documentation of a trial of anti-depressants or AEDs such as gabapentin or Lyrica for this patient.

IMR ISSUES, DECISIONS AND RATIONALES

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

Oxycodone 10mg per 05/09/14 QTY90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines OPIOIDS Page(s): 78-80.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Ongoing Management Page(s): 78-81.

Decision rationale: As stated on pages 78-80 of CA MTUS Chronic Pain Medical Treatment Guidelines, there are no trials of long-term opioid use in neuropathic pain. Failure to respond to a time-limited course of opioids has led to the suggestion of reassessment and consideration of alternative therapy. Four domains have been proposed as most relevant for ongoing monitoring of CHRONIC pain patients on opioids: pain relief, side effects, physical and psychosocial functioning, and the occurrence of any potentially aberrant (or nonadherent) drug-related behaviors. The monitoring of these outcomes over time should affect therapeutic decisions and provide a framework for documentation of the clinical use of these controlled drugs. In this case, the patient had been taking opioids for pain since at least December 2013. Records show an improvement in pain scores and functional abilities. However, there is neither a documentation of a plan to taper the medication nor evidence of a trial to use the lowest possible dose. Side effects were not adequately explored. There is no recent urine drug screen that would provide insight regarding the patient's compliance to the prescribed medication. The medical necessity for continued use is not established because the guideline criteria are not met. Therefore, the request for Oxycodone 10mg per 05/09/14 QTY90 is not medically necessary.

Zanaflex 2mg per 05/09/14 QTY:60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS Page(s): 70,73.

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

Decision rationale: According to page 63 of the CA MTUS Chronic Pain Medical Treatment Guidelines, non-sedating muscle relaxants are recommended with caution as a second-line option for short-term treatment of acute exacerbations in patients with chronic low back pain. In this case, the patient has been on Zanaflex since February 2014. However, there is no documentation concerning pain relief and functional improvement derived from its use. Long-term use of muscle relaxant was not recommended. Therefore, the request for Zanaflex 2mg per 05/09/14 QTY:60 is not medically necessary.

Naprosyn 550mg ,per 05/09/14 QTY:50: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): 68-69.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): 46.

Decision rationale: As stated on page 46 of the California MTUS Chronic Pain Medical Treatment guidelines, NSAIDs are recommended at the lowest dose for the shortest period in patients with moderate to severe pain and that there is no evidence of long-term effectiveness for pain or function. In this case, the patient had been using NSAIDs intermittently. However, the patient's pain is chronic and the guidelines do not recommend long-term use of NSAIDs. Moreover, the records do not show that the patient derives benefit from its use. Therefore, the request for Naprosyn 550mg, per 05/09/14 QTY:50 is not medically necessary.

Omeprazole 20mg , per 05/0914 QTY 60: 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 NSAIDS, GI symptoms and cardiovascular risk Page(s): 68.

Decision rationale: According to page 68 of the CA MTUS Chronic Pain Medical Treatment Guidelines, proton pump inhibitors, such as omeprazole, are indicated in patients taking NSAIDS who are also at intermediate risk for gastrointestinal events and no cardiovascular disease. GI and cardiovascular risk factors include: age > 65 years, history of peptic ulcer, GI bleeding or perforation; concurrent use of ASA, corticosteroids, or anticoagulant; or on high-dose/multiple NSAIDs. In this case, the records provided do not document any GI complaint or evidence that the patient was at intermediate risk for gastrointestinal events. The request for Naprosyn was also not certified. Therefore, the request for Omeprazole 20mg, per 05/0914 QTY 60 is not medically necessary.

Lidoderm 5% patch , per 05/09/14 QTY: 30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesic Page(s): 111-112.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Lidoderm Page(s): 56-57.

Decision rationale: As stated on page 77 of the CA MTUS Chronic Pain Medical Treatment Guidelines, Lidoderm is the brand name for a lidocaine patch produced by Endo Pharmaceuticals. Topical lidocaine may be recommended for localized peripheral pain after there has been evidence of a trial of first-line therapy (tri-cyclic or SNRI anti-depressants or an AED

such as gabapentin or Lyrica). This is not a first-line treatment and is only FDA approved for post-herpetic neuralgia. In this case, patient's clinical manifestations are consistent with neuropathic pain; hence, Lidoderm patch may be a reasonable treatment option. However, records do not show that the patient had already a trial of first-line therapy. Guideline criteria are not met. Therefore, the request Lidoderm 5% patch , per 05/09/14 QTY: 30 is not medically necessary.