

Case Number:	CM14-0093917		
Date Assigned:	08/08/2014	Date of Injury:	06/06/1999
Decision Date:	10/03/2014	UR Denial Date:	05/13/2014
Priority:	Standard	Application Received:	05/13/2014

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 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 50-year-old female with a 6/6/99 date of injury. At the time (4/14/14) of request for authorization for Norco 10/325 mg #60, Tizanidine 4 mg #60, Lidoderm Patch 5% Refills X2, and Temazepam 15 mg #60, there is documentation of subjective (neck pain, headaches, upper back pain, lower back pain, bilateral shoulder pain, bilateral feet pain, burning pain in the extremities, depression, and poor sleep quality) and objective (paracervical muscle spasm and tenderness; tenderness over the superior border of the trapezius muscle, and limited cervical range of motion; lumbar paravertebral muscle and tenderness in the lower lumbar region) findings, current diagnoses (failed neck surgery syndrome, cervicogenic headaches, history of major depression, and insomnia), and treatment to date (Temazepam since at least 2/21/14 with improved sleep quality, ongoing therapy with Norco with increased activities of daily living, and Lidoderm patch and Tizanidine since at least 2/21/14 with decreased pain levels). In addition, medical report identifies ongoing treatment with Savella (SNRI). Regarding Norco 10/325 mg #60, there is no 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. Regarding Tizanidine 4 mg #60, there is no documentation of acute exacerbation of chronic pain, short-term (less than two weeks) treatment, and functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications as a result of use of Tizanidine. Regarding Lidoderm Patch 5% Refills X2, there is no documentation of evidence that a trial of first-line therapy (tri-cyclic or SNRI anti-depressants or an AED such as gabapentin or Lyrica) has failed; and functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications as a result of use of

Lidoderm patch. Regarding Temazepam 15 mg #60, there is no documentation of short-term (less than 4 weeks) treatment and functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications as a result of use of Temazepam.

IMR ISSUES, DECISIONS AND RATIONALES

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

Norco 10/325 mg #60: Upheld

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

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 failed neck surgery syndrome, cervicogenic headaches, history of major depression, and insomnia. In addition, given documentation of ongoing treatment with Norco with increased activities of daily living, there is documentation of functional benefit or improvement as an increase in activity tolerance as a result of use of Norco. However, there is no 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. Therefore, based on guidelines and a review of the evidence, the request for Norco 10/325 mg #60 is not medically necessary.

Tizanidine 4 mg #60: Upheld

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

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) 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 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 failed neck surgery syndrome, cervicogenic headaches, history of major depression, and insomnia. In addition, there is documentation of chronic pain and spasticity. However, there is no documentation of acute exacerbation of chronic pain. In addition, given documentation of ongoing treatment with Tizanidine since at least 2/21/14, there is no documentation of short-term (less than two weeks) treatment. Furthermore, despite documentation of decreased pain levels with Tizanidine, there is no (clear) documentation 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 as a result of use of Tizanidine. Therefore, based on guidelines and a review of the evidence, the request for Tizanidine 4 mg #60 is not medically necessary.

Lidoderm Patch 5% Refills X2: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics - Lidocaine.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Lidoderm (lidocaine patch) Page(s): 56-57. 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 identifies documentation of neuropathic pain after there has been evidence that a trial of first-line therapy (tri-cyclic or SNRI anti-depressants or an AED such as gabapentin or Lyrica) has failed, as criteria necessary to support the medical necessity of a lidocaine patch. 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 failed neck surgery syndrome, cervicogenic headaches, history of major depression, and insomnia. In addition, there is documentation of neuropathic pain. However, given documentation of ongoing treatment with Savella (SNRI), there is no documentation of evidence that a trial of first-line therapy (tri-cyclic or SNRI anti-depressants or an AED such as gabapentin or Lyrica) has failed. In addition, despite documentation of decreased pain levels with Lidoderm patch, there is no (clear) documentation 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 as a result of use of Lidoderm patch. Therefore, based on guidelines and a review of the evidence, the request for Lidoderm Patch 5% Refills X2 is not medically necessary.

Temazepam 15 mg #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines Page(s): 24. 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 identifies that benzodiazepines are not recommended for long-term and that most guidelines limit use to 4 weeks. 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 failed neck surgery syndrome, cervicogenic headaches, history of major depression, and insomnia. However, given documentation of ongoing treatment with Temazepam since at least 2/21/14, there is no documentation of short-term (less than 4 weeks) treatment. In addition, despite documentation of improved sleep quality with Temazepam, there is no (clear) documentation 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 as a result of use of Temazepam. Therefore, based on guidelines and a review of the evidence, the request Temazepam 15 mg #60 is not medically necessary.