

Case Number:	CM14-0184370		
Date Assigned:	11/12/2014	Date of Injury:	05/01/2007
Decision Date:	01/30/2015	UR Denial Date:	10/27/2014
Priority:	Standard	Application Received:	11/05/2014

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 Internal Medicine and is licensed to practice in New York. 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 claimant is a 47 yo female who sustained an industrial injury on 05/01/2007. The mechanism of injury was not provided for review. Her diagnoses include right lumbar radiculopathy, lumbar facet pain, sacroiliitis, failed back syndrome, and depression secondary to chronic pain. She continues to complain of low back, hip and lower extremity pain. She also remains depressed despite medical therapy with Zoloft. Physical examination reveals tenderness and spasm along the lumbar paraspinal muscles, stiffness, and increased pain with flexion compared to extension of the lower back. There is dysesthesia to light touch bilaterally in the L5-S1 dermatome. Treatment has consisted of medical therapy, psychotherapy, a home exercise program and surgery. The treating provider has requested Avinza 30mg #30, Norco 10/325mg #90, Clonazepam 0.5mg #30, Zoloft 100mg #30, Tizanidine 4mg #30, Topamax 50mg #60, Trazadone 50mg #30, and Lyrica 150mg #90.

IMR ISSUES, DECISIONS AND RATIONALES

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

Avinza 30mg #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioid use for Chronic Pain.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 61, 91-97.

Decision rationale: Avinza is indicated for the treatment of moderate to severe pain. The treatment of chronic pain with these agents requires review and documentation of pain relief, functional status, appropriate medication use, and side effects. Pain assessment should include current pain: last reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid, and the duration of pain relief. Per the medical documentation there has been no documentation of the medications pain relief effectiveness and no clear documentation that the claimant has responded to Avinza therapy. In addition she continues with the use of Norco, another opiate medication, for breakthrough pain. According to the California MTUS Guidelines there has to be certain criteria followed including an ongoing review and documentation of pain relief and functional status. This does not appear to have occurred with this patient. Medical necessity for the requested item has not been established. The requested item is not medically necessary.

Norco 10/325mg #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioid use for Chronic Pain.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 91-97.

Decision rationale: The documentation indicates the enrollee has been treated with opioid therapy with Avinza and Norco for pain control. Per California MTUS Guidelines, short-acting opioids such as Norco are seen as an effective method in controlling chronic pain. They are often used for intermittent or breakthrough pain. The treatment of chronic pain with any opioid agent requires review and documentation of pain relief, functional status, appropriate medication use, and side effects. Pain assessment should include current pain: last reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid, and the duration of pain relief. Per the medical documentation there has been no documentation of the medication's pain relief effectiveness and no clear documentation that she has responded to ongoing opioid therapy. According to the California MTUS Guidelines there has to be certain criteria followed including an ongoing review and documentation of pain relief and functional status. This does not appear to have occurred with this patient. The patient has continued pain despite the use of long and short acting opioid medications. Medical necessity for Norco 10/325 has not been established. The requested treatment is not medically necessary.

Clonazepam 0.5mg #30: Upheld

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

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

Decision rationale: Clonazepam is a short-acting benzodiazepine drug having anxiolytic, sedative, and hypnotic properties. The medication is used in conjunction with antidepressants for the treatment of depression with anxiety, and panic attacks. Per California MTUS Guidelines, benzodiazepines are not recommended for long-term use for the treatment of chronic pain because long-term efficacy is unproven and there is a risk of dependency. Most guidelines limit use to four weeks. The medical documentation indicates the claimant has continued symptoms of depression with anxiety and sleep issues related to the work injuries. The claimant is maintained on an anti-depressant, Zoloft and remains depressed. She would benefit from a mental health evaluation to determine the appropriate medical therapy for her depression, anxiety and sleep issues. Medical necessity for the requested medication, Clonazepam has not been established. The requested treatment is not medically necessary.

Zoloft 100mg #30: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 13- 16.

Decision rationale: The requested medication, Zoloft 100mg is not medically necessary for the treatment of the patient's condition. The claimant has depression as part of his chronic pain condition. Sertraline is an antidepressant in the group of drugs called selective serotonin reuptake inhibitors (SSRIs). The medical documentation indicates the patient remains depressed despite regular use of the medication. The medication is to be weaned. Medical necessity for the requested item has not been established. The treatment is not medically necessary.

Tizanidine 4mg 330: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants (for pain).

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

Decision rationale: Tizanidine (Zanaflex) is a centrally acting alpha-2-adrenergic agent FDA approved for the treatment of spasticity; unlabeled use for low back pain. It is indicated for the treatment of chronic myofascial pain and as adjunct treatment for the treatment of fibromyalgia. Per California MTUS Guidelines muscle relaxants are not considered any more effective than nonsteroidal anti-inflammatory medications alone. The claimant still has palpable muscle spasm on exam despite long term use of this medication which may indicate tolerance to this medication. Medical necessity for the requested treatment has not been established. The requested treatment is not medically necessary.

Topamax 50mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-Epilepsy Drugs (AEDs).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 15.

Decision rationale: The recommended medication, Topiramate is not medically necessary for the treatment of the patient's condition. Per the documentation she has neuropathic pain related to his chronic back pain condition. The medication is part of her medical regimen and per California MTUS Guidelines 2009 antiepilepsy medications are a first line treatment for neuropathic pain. The patient has not reported a reduction in her pain with the medical therapy which would be defined as a 50% reduction which would represent a "good" response. Medical necessity has not been documented and the requested treatment is not medically necessary for treatment of the patient's chronic pain condition.

Trazodone 50mg #30: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 16-17.

Decision rationale: Trazodone is indicated for the treatment of sleep disorders including insomnia and depression. The medication has anxiolytic and sleep-inducing effects. There is no documentation in functional improvement in the claimant's pain or sleep with the chronic use of Trazodone. Given the effectiveness of the medication has not been documented; medical necessity has not been established. The requested treatment is not medically necessary.

Lyrica 150mg #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-Epilepsy Drugs (AEDs).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 15, 20.

Decision rationale: The recommended medication, Lyrica is not medically necessary for the treatment of the patient's condition. Per the documentation she has neuropathic pain related to her chronic back condition. The medication is part of her medical regimen and per California MTUS Guidelines 2009 antiepilepsy medications are a first line treatment for neuropathic pain. Lyrica is FDA approved for diabetic neuropathy and post-herpetic neuralgia and has been used effectively for the treatment of neuropathic pain. The patient has not reported a reduction in her pain with the medical therapy which would be defined as a 50% reduction which would represent a "good" response. Medical necessity has not been documented and the requested treatment is not medically necessary for treatment of the patient's chronic pain condition.

