

Case Number:	CM14-0199367		
Date Assigned:	12/09/2014	Date of Injury:	04/19/1989
Decision Date:	01/23/2015	UR Denial Date:	11/18/2014
Priority:	Standard	Application Received:	11/26/2014

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 Family Practice 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 members DOI is 4/19/89. The specifics of the injury are not indicated. The member is reported to have undergone multiple orthopedic procedures to include: L5-S1 in 1990, a second lumbar surgery for fusion at L4-S1 in 2009 and a recent R L4-5 revision laminectomy and L4-S1 hardware removal in May 2013. The member has not had resolution of her symptoms. At the time of the review she was noted to be experiencing chronic LBP radiating into her RLE. She reported pain at 8/10 with medications and 10/10 without medications. She felt recent changes in medications because of Non-Certification had forced her from the use of Kadian, which she felt had been useful to MS-Contin which to her was not as effective. She had also been changed from Soma To Zanaflex for muscle spasms. She indicated she was having more problems with lumbar and R leg spasms. She noted interference with her sleep as well as a decrease in overall function with the change in medications. Examination showed an antalgic gait on the R, limited ROM in extension with pain over the R SI joint, a positive Gaenslen's and FABER's sign was noted and straight leg raising was reported as negative. Weakness was present throughout the LE. Palpation of the lumbar spine showed paraspinal muscle spasm. There was sensory loss in the L5 nerve root distribution and absent R Achilles reflex. The diagnoses under treatment included: Lumbar Disc Disorder, Lumbar R Radiculopathy, Chronic LBP, Post Lumbar Laminectomy Syndrome and Insomnia. Medications included MS-Contin 15mg tid 90, Percocet 7.5.325 1prn 30, Neurontin 800mg qid 120 and Zanaflex 4mg bid prn 60. The items in contention reflect the non-certification for Zanaflex, MS-Contin and Percocet.

IMR ISSUES, DECISIONS AND RATIONALES

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

Zanaflex 4 mg, sixty count: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Part 2 Page(s): 62, 66.

Decision rationale: Non-sedating muscle relaxants can be recommended with caution as second line options for short term treatment of acute exacerbations in patients with chronic LBP. In most cases they show no additional benefit beyond NSAID's in pain and overall improvement and no additional benefit in combination with NSAID's. Tizanidine has shown evidence for efficacy with myofascial pain syndrome and possibly fibromyalgia. It has been associated with somnolence, dizziness, weakness and hepatotoxicity. The physical examination reported spasms in the back and R leg and examination reported paraspinal spasm. It is unclear if there was no significant reported flare. Of note the member is not on any NSAID's and it is unclear the reason why. Efficacy for muscle relaxants appears to diminish with time and maximal benefit appears to decline after approximately 4 days. Sedation is the most common class effect. She also reports issues with insomnia and it remains quite likely that the sedative side effects were playing the dominant role here. Based on a failure to show functional improvement, any recent injury and the lack of use of a primary agent such as an NSAID, the request is not medically necessary.

Percocet 7.5/325 mg, thirty count: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Part 2 Page(s): 11, 79-81, 86, 87, 93, 95.

Decision rationale: A meta-analysis found that opioids were more effective than placebo for reducing pain intensity but the benefit for physical function was small and was considered questionable for clinical relevance. Opioids can be recommended on a trial basis for short-term use after there has been evidence of failure of first-line medication options such as acetaminophen or NSAIDs when there is evidence of moderate to severe pain. They would be used in conjunction with these medications rather than as a replacement as in this case. If chronic use is entertained then before initiating therapy, the patient should set goals, and the continued use of opioids should be contingent on meeting these goals. Baseline pain and functional assessments should be made. Function should include social, physical, psychological, daily and work activities. Continuation of the use of opioids would be best assessed on the basis of a return to work with evidence for improved functioning and reduced pain. The primary risk with continued use is that 36 to 56% of users have a lifetime risk for substance use disorders. Additionally there is the risk of diversion, tolerance and hyperalgesia resulting in gradual increases in medication dosing with evidence for decreasing benefit. With continuous pain extended-release opioids are recommended. Patients on this modality may require a dose of

quick acting "rescue" opioids. The need for extra opioid can be a guide to determine the sustained release dose required. In this instance use of Percocet is prescribed on a qd prn basis which would meet the criteria for use as a rescue medication. However weaning of opioid analgesics is recommended if there is no overall improvement in function, unless there are extenuating circumstances. This member was found to have had a stable condition with no documented evidence for a sustained reduction in pain or improvement in practical function related to the use of opioids over an extended period of time. In the face of evidence for limited utility for improved function, recommendations for short-term use of short acting opioids and the ongoing risk for rebound pain and dependence, continued use of Percocet cannot be supported. The request is not medically necessary.

MS Contin 15 mg, ninety count: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Part 2 Page(s): 13, 78, 79-81, 86, 87, 93, 95.

Decision rationale: MS-Contin is indicated for the management of persistent chronic pain which is moderate to severe requiring continuous around the clock opioid therapy. The logic behind the sustained release dosing is to avoid the peaks and valleys in analgesia that can drive the use of narcotic analgesics when the patient is always behind the pain power curve in addition to avoiding the narcotic "high" that drives dependency. Assessment of treatment efficacy should include not only pain outcomes, but also an evaluation of function, changes in use of other analgesic medication, sleep quality and duration. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. Consideration should be given to discontinuing the use of opioids when there is no overall improvement in functioning as in this patient (best is 8/10). This is especially true in the face of the potential for dependence, hyperalgesia syndrome and misuse. The member has neither returned to work nor exhibited any sustained impact in markers of improved function such as exercise tolerance, lifting, carrying, standing, walking distance and an ability to participate in family activities. In the absence of evidence for a sustained benefit from these medications, the request is not medically necessary.