

Case Number:	CM14-0025445		
Date Assigned:	06/11/2014	Date of Injury:	04/19/1991
Decision Date:	04/13/2015	UR Denial Date:	02/05/2014
Priority:	Standard	Application Received:	02/27/2014

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
 State(s) of Licensure: Texas, New York, California
 Certification(s)/Specialty: Preventive Medicine, Occupational Medicine

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 applicant is a represented 68-year-old [REDACTED] beneficiary who has filed a claim for chronic neck and low back pain reportedly associated with an industrial injury of April 19, 1991. In a Utilization Review Report dated February 5, 2014, the claims administrator failed to approve requests for Opana, Duragesic, OxyContin, and Zanaflex. The claims administrator referenced a January 27, 2014 RFA form in its determination. The applicant's attorney subsequently appealed. On January 30, 2014, the applicant reported ongoing complaints of neck and low back pain. The applicant had undergone earlier cervical and lumbar spine surgeries, it was acknowledged. The applicant's medication list included Tenormin, Catapres, Duragesic, hydrochlorothiazide, Mobic, Opana, OxyContin, and Zanaflex. The applicant was asked to continue current medications. 7/10 pain complaints were noted. The applicant's works status was not clearly outlined on this occasion, although it did not appear that the applicant was working. The applicant exhibited a visibly antalgic gait. On December 30, 2013, the applicant again reported ongoing complaints of neck and low back pain, 7/10. A visibly antalgic gait was appreciated. The applicant's medication list was described as comprising of Tenormin, Catapres, Duragesic, hydrochlorothiazide, Mobic, Opana, OxyContin, and Zanaflex. The attending provider stated that the applicant was improved with the current treatment plan but did not elaborate further.

IMR ISSUES, DECISIONS AND RATIONALES

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

OPANA IR 10 MG: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines OPIOIDS, CRITERIA FOR USE Page(s): 76-80.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 7) When to Continue Opioids Page(s): 80.

Decision rationale: No, the request for Opana, a short-acting opioid, was not medically necessary, medically appropriate, or indicated here. As noted on page 80 of the MTUS Chronic Pain Medical Treatment Guidelines, the cardinal criteria for continuation of opioid therapy include evidence of successful return to work, improved functioning, and/or reduced pain achieved as a result of the same. Here, however, the applicant's work status was not outlined on several progress notes, referenced above, of late 2013 and/or early 2014. On those dates the attending provider likewise failed to outline any meaningful or material improvements in function or quantifiable decrements in pain effected as a result of ongoing opioid therapy (if any). All of the foregoing, taken together, did not make a compelling case for continuation of the same. Therefore, the request was not medically necessary.

DURAGESIC 50 MCG/HR: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines OPIOIDS, CRITERIA FOR USE Page(s): 76-80.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 7) When to Continue Opioids Page(s): 80.

Decision rationale: Similarly, the request for Duragesic, a long-acting opioid, was likewise not medically necessary, medically appropriate, or indicated here. As noted on page 80 of the MTUS Chronic Pain Medical Treatment Guidelines, the cardinal criteria for continuation of opioid therapy include evidence of successful return to work, improved functioning, and/or reduced pain achieved as a result of the same. Here, the applicant's work status was not clearly articulated on multiple progress notes, referenced above, suggesting that the applicant was not, in fact, working. The applicant continued to report pain complaints as high as 7/10, despite ongoing Duragesic usage. The attending provider failed to outline any meaningful or material improvements in function or quantifiable decrements in pain effected as a result of ongoing Duragesic usage (if any). Therefore, the request was not medically necessary.

OXYCONTIN 40 MG: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines OPIOIDS, CRITERIA FOR USE Page(s): 76-80.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 4) On-Going Management Page(s): 78.

Decision rationale: Similarly, the request for OxyContin, another long-acting opioid, was likewise not medically necessary, medically appropriate, or indicated here. As noted on page 78 of the MTUS Chronic Pain Medical Treatment Guidelines, the lowest possible dose of opioid should be employed to improve pain and function. Here, however, the attending provider did not furnish a clear or compelling rationale for concurrent usage of two separate long-acting opioids, Duragesic and OxyContin. Therefore, the request was not medically necessary.

ZANAFLEX 4 MG: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines MUSCLE RELAXANTS (FOR PAIN) Page(s): 63-66.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Functional Restoration Approach to Chronic Pain Management Page(s): 66.

Decision rationale: Finally, the request for Zanaflex (tizanidine), an antispasmodic medication, was not medically necessary, medically appropriate, or indicated here. While page 66 of the MTUS Chronic Pain Medical Treatment Guidelines does acknowledge that tizanidine or Zanaflex, an antispasmodic medication, is FDA approved in the management of spasticity but can be employed off-label for low back pain, as was/is present here, this recommendation is, however, qualified by commentary made on page 7 of the MTUS Chronic Pain Medical Treatment Guidelines to the effect that an attending provider should incorporate some discussion of medication efficacy into his choice of recommendations. Here, however, the applicant continues to report ongoing complaints of neck and low back pain as high as 7/10, despite ongoing Zanaflex usage. Ongoing usage of Zanaflex failed to curtail the applicant's reliance on opioid agents such as Duragesic, OxyContin, etc. All of the foregoing, taken together, suggests a lack of functional improvement as defined in MTUS 9792.20f, despite ongoing usage of Zanaflex (tizanidine). Therefore, the request was not medically necessary.