

Case Number:	CM15-0008252		
Date Assigned:	01/27/2015	Date of Injury:	03/23/2009
Decision Date:	03/20/2015	UR Denial Date:	12/17/2014
Priority:	Standard	Application Received:	01/14/2015

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: California

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Pain Management

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 56 year old male injured worker suffered and industrial injury on 3/23/2009. The diagnoses were left lumbar radiculopathy and depression. The diagnostics were magnetic resonance imaging and electromyography. The treatments were medications, epidural steroid injections, H-wave, physical therapy. The treating provider reported persistent low back pain with radiating to right leg, difficulty sleeping with pain level at 6/10 with hypersensitivity to the right leg. The provider noted pain relief and functional improvement with Norco. There were no side effects, a pain contract was on file, UDS was done, and there were no aberrant behaviors. The provider noted symptoms suggestive of restless leg syndrome and recommended Horizant. The Utilization Review Determination on 12/17/2014 non-certified: 1. Norco 10/325mg #150 modified to #120, citing MTUS Chronic Pain Treatment Guidelines, opioids 2. Effexor XR 75mg #90 with 1 refill, citing, MTUS Chronic Pain Treatment Guidelines, anti-depressants 3. Zanaflex 4mg #30 with 1 refill, citing Official Disability Guidelines, pain and MTUS Chronic Pain Treatment Guidelines, muscle relaxants 4. Xanax 0.5mg #30 modified to #20, citing MTUS Chronic Pain Treatment Guidelines 5. Horizant 600mg #60 no refill, citing Food and Drug Administration

IMR ISSUES, DECISIONS AND RATIONALES

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

Norco 10/325mg #150: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 82-88.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use Page(s): 76-80.

Decision rationale: Regarding the request for Norco, California Pain Medical Treatment Guidelines note that it is an opiate pain medication. Due to high abuse potential, close follow-up is recommended with documentation of analgesic effect, objective functional improvement, side effects, and discussion regarding any aberrant use. Guidelines go on to recommend discontinuing opioids if there is no documentation of improved function and pain. Within the documentation available for review, there is indication that the medication is improving the patient's function and pain without intolerable side effects and no evidence of aberrant use. In light of the above, the currently requested Norco is medically necessary.

Norco 10/325mg #150 DND until 12/25/2014: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 82-88.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use Page(s): 76-80.

Decision rationale: Regarding the request for Norco, California Pain Medical Treatment Guidelines note that it is an opiate pain medication. Due to high abuse potential, close follow-up is recommended with documentation of analgesic effect, objective functional improvement, side effects, and discussion regarding any aberrant use. Guidelines go on to recommend discontinuing opioids if there is no documentation of improved function and pain. Within the documentation available for review, there is indication that the medication is improving the patient's function and pain without intolerable side effects and no evidence of aberrant use. However, another prescription for Norco was provided and another concurrent prescription to be filled at a later date is not conducive to the regular reevaluation for efficacy, continued need, side effects, and appropriate medication usage recommended by the CA MTUS. As such, there is no clear indication for ongoing use of the medication. Opioids should not be abruptly discontinued, but unfortunately, there is no provision to modify the current request to allow tapering. In light of the above issues, the currently requested Norco is not medically necessary.

Zanaflex 4mg #30mg 1 Refill: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain) Page(s): 67. Decision based on Non-MTUS Citation ODG-Pain (chapter)

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants (for pain) Page(s): 63-66.

Decision rationale: Regarding the request for Zanaflex, Chronic Pain Medical Treatment Guidelines support the use of nonsedating muscle relaxants to be used with caution as a 2nd line option for the short-term treatment of acute exacerbations of pain. Within the documentation available for review, it does not appear that this medication is being prescribed for the short-term treatment of an acute exacerbation, as recommended by guidelines. In the absence of such documentation, the currently requested Zanaflex is not medically necessary.

Xanax 0.5mg #30 1 refill: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 23.

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

Decision rationale: Regarding the request for Xanax (alprazolam), Chronic Pain Medical Treatment Guidelines state the benzodiazepines are not recommended for long-term use because long-term efficacy is unproven and there is a risk of dependence. Most guidelines limit use to 4 weeks tolerance to anxiolytic effects occurs within months and long-term use may actually increase anxiety. A more appropriate treatment for anxiety disorder is an antidepressant. Within the documentation available for review, there is no documentation identifying any objective functional improvement as a result of the use of the medication and no rationale provided for long-term use of the medication despite the CA MTUS recommendation against long-term use. Benzodiazepines should not be abruptly discontinued, but unfortunately, there is no provision to modify the current request to allow tapering. In the absence of such documentation, the currently requested Xanax (alprazolam) is not medically necessary.

Horizant 600mg #60 1 Refill: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation U.S. Food and Drug Administration (FDA)

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation <http://www.drugs.com/pro/horizant.html>

Decision rationale: Regarding the request for Horizant, CA MTUS and ODG do not address treatment of restless legs syndrome. FDA indications for Horizant include restless legs syndrome and postherpetic neuralgia. Within the documentation available for review, the provider notes suspicion for restless legs syndrome and recommended the use of Horizant. However, the patient was provided with samples as well as a prescription for #60 with one refill. FDA recommendation for restless legs syndrome is 600 mg once per day. While enough medication for a month of treatment would be reasonable to identify efficacy for this patient, there is no clear rationale for #60 with one refill and, unfortunately, there is no provision for modification of the current request. In light of the above issues, the currently requested Horizant is not medically necessary.

