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| Case Number: | CM15-0184444 | | |
| Date Assigned: | 09/24/2015 | Date of Injury: | 02/12/2003 |
| Decision Date: | 11/02/2015 | UR Denial Date: | 08/20/2015 |
| Priority: | Standard | Application Received: | 09/18/2015 |

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: North Carolina

Certification(s)/Specialty: Family Practice

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 injured worker is a 46-year-old male who sustained an industrial injury February 12, 2003. On June 2, 2015, he underwent a lumbar epidural steroid L4-L5 injection under fluoroscopy. According to a treating physician's office visit notes dated August 6, 2015, the injured worker presented with complaints of back pain that is radiating down his right leg with burning. The physician documents he had an epidural injection, which gave him relief (not described). The injured worker reports he cannot function without pain medication- he gets a 50% reduction in pain, which increases his ability to function. Physical examination revealed; back exam very limited range, can flex 20 degrees, cannot stand up straight, palpation reveals muscle spasm in the lumbar trunk with antalgic posture; absent left Achilles reflex; sensory loss in the left lateral calf and bottom of his foot; 4 out of 5 weakness in left thigh flexion; left shoulder- limited range with positive impingement sign, mild crepitus on circumduction passively; left knee- full active range, McMurray's sign is negative, patellar compression is painful, mild joint effusion noted. Impression is documented as low back pain with radicular symptoms, left leg- MRI revealing a left sided L5-S1 disc herniation impinging the left L5 nerve root, (dated March 10, 2014, report in medical record); left shoulder decompression with ongoing myofascial pain; left knee pain with chondromalacia patella and degenerative joint disease with history of sprain, strain injury. Request for authorization forms dating back to March 24, 2015, revealed the injured worker was prescribed Percocet and Zanaflex in the same dosage as the current request. Treatment plan included discussion regarding narcotic contract, urine drug screens appropriate and at issue, request for authorization dated August 12, 2015, for Percocet 10-325mg #90 and Zanaflex 4mg

#30. According to utilization review dated August 20, 2015, the request for Zanaflex 4mg #30 between August 6, 2015 and October 18, 2015 is non-certified. The request for Percocet 10-325mg #90 between August 6, 2015 and October 18, 2015 is non-certified.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 prescription of Zanaflex 4mg #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Muscle relaxants (for pain).

Decision rationale: The California chronic pain medical treatment guidelines section on muscle relaxants states: Recommend non-sedating muscle relaxants with caution as a second-line option for short-term treatment of acute exacerbations in patients with chronic LBP. (Chou, 2007) (Mens, 2005) (Van Tulder, 1998) (Van Tulder, 2003) (Van Tulder, 2006) (Schnitzer, 2004) (See, 2008) Muscle relaxants may be effective in reducing pain and muscle tension, and increasing mobility. However, in most LBP cases, they show no benefit beyond NSAIDs in pain and overall improvement. In addition, there is no additional benefit shown in combination with NSAIDs. Efficacy appears to diminish over time, and prolonged use of some medications in this class may lead to dependence. (Homik, 2004) (Chou, 2004) This medication is not intended for long-term use per the California MTUS. The medication has not been prescribed for the flare-up of chronic low back pain but rather ongoing back pain this is not an approved use for the medication. For these reasons, criteria for the use of this medication have not been met. Therefore, the request is not medically necessary.

1 prescription of Percocet 10/325mg #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids for chronic pain.

Decision rationale: The California chronic pain medical treatment guidelines section on opioids states for ongoing management: On-Going Management. Actions Should Include: (a) Prescriptions from a single practitioner taken as directed, and all prescriptions from a single pharmacy. (b) The lowest possible dose should be prescribed to improve pain and function. (c) Office: Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. Pain assessment should include current pain; the least reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid; how long it takes for pain relief; and how long pain relief lasts. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or

improved quality of life. Information from family members or other caregivers should be considered in determining the patient's response to treatment. The 4 A's for Ongoing Monitoring: Four domains have been proposed as most relevant for ongoing monitoring of chronic pain patients on opioids: pain relief, side effects, physical and psychosocial functioning, and the occurrence of any potentially aberrant (or non-adherent) drug-related behaviors. These domains have been summarized as the "4 A's" (analgesia, activities of daily living, adverse side effects, and aberrant drug taking behaviors). The monitoring of these outcomes over time should affect therapeutic decisions and provide a framework for documentation of the clinical use of these controlled drugs. (Passik, 2000)

(d) Home: To aid in pain and functioning assessment, the patient should be requested to keep a pain diary that includes entries such as pain triggers, and incidence of end-of-dose pain. It should be emphasized that using this diary will help in tailoring the opioid dose. This should not be a requirement for pain management.

(e) Use of drug screening or inpatient treatment with issues of abuse, addiction, or poor pain control.

(f) Documentation of misuse of medications (doctor-shopping, uncontrolled drug escalation, drug diversion).

(g) Continuing review of overall situation with regard to non-opioid means of pain control.

(h) Consideration of a consultation with a multidisciplinary pain clinic if doses of opioids are required beyond what is usually required for the condition or pain does not improve on opioids in 3 months. Consider a psych consult if there is evidence of depression, anxiety or irritability. Consider an addiction medicine consult if there is evidence of substance misuse.

When to Continue Opioids: (a) If the patient has returned to work; (b) If the patient has improved functioning and pain. (Washington, 2002) (Colorado, 2002) (Ontario, 2000) (VA/DoD, 2003) (Maddox-AAPM/APS, 1997) (Wisconsin, 2004) (Warfield, 2004)

The long-term use of this medication class is not recommended per the California MTUS unless there documented evidence of benefit with measurable outcome measures and improvement in function. There is no documented significant decrease in objective pain measures such as VAS scores for significant periods of time. There are no objective measures of improvement of function or how the medication improves activities. The work status is not mentioned. Therefore, not all criteria for the ongoing use of opioids have been met and the request is not medically necessary.