

Case Number:	CM15-0187191		
Date Assigned:	09/29/2015	Date of Injury:	06/20/2008
Decision Date:	12/01/2015	UR Denial Date:	09/15/2015
Priority:	Standard	Application Received:	09/23/2015

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 injured worker is a 62 year old male who sustained an industrial injury on 6-2-08. Diagnoses per the request for authorization dated 9-9-15 are post lumbar laminectomy syndrome, low back pain, depression not otherwise specified, radiculopathy, pain disorder with both psychological factors and an orthopedic condition, myalgia and myositis not otherwise specified, arthrodesis status. Previous treatment includes a spinal cord stimulator, medication, failed injections, and physical therapy. In a progress report dated 9-8-15, the physician notes complaint of back pain radiating from the low back down the back of both legs. Pain is rated at 7 out of 10 with medications and 8 out of 10 without medications. It is noted quality of sleep is poor and that activity level has remained the same. He reports he continues to have pain flare ups but they have dramatically decreased since having the spinal cord stimulator implant (implanted 7-21-15) and that he recovers from the flare-ups more rapidly. The physician notes he is stable on current medications and has not changed the essential regimen in greater than 6 months and function and activities of daily living improved optimally on current doses of medications. A pain agreement is noted as reviewed. Current medication is Effexor XR 150mg 2 a day, Gabapentin 300mg 1 three times a day, Tizanidine HCL 2mg 1 three times a day, Hydrocodone-Acetaminophen 10- 325mg 1 three times a day as needed, Opana ER 30mg 1 twice daily, Clonazepam 0.5mg 2-3 at bedtime, Fluticasone Prop, Latanoprost, Lisinopril, and Simvastatin. Physical exam of the lumbar spine reveals range of motion is restricted with flexion to 40 degrees limited by pain and extension to 10 degrees limited by pain and lumbar facet loading is positive on both sides. He has an antalgic, slow, stooped gait. On 9-15-15, the requested treatment of Hydrocodone- Acetaminophen 10-325mg #90, Opana ER 30mg #80, Tizanidine HCL 2mg #90, Gabapentin 300mg #90, and Effexor XR 150mg #60 was non-certified.

IMR ISSUES, DECISIONS AND RATIONALES

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

Hydrocodone/Acetaminophen 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 (Classification), Opioids, California Controlled Substance Utilization Review and Evaluation System (CURES) [DWC], Opioids, criteria for use, Opioids for chronic pain.

Decision rationale: Regarding the request for Norco (hydrocodone/acetaminophen), Chronic Pain Medical Treatment Guidelines state that Norco 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 further specify for discontinuation of opioids if there is no documentation of improved function and pain. Within the documentation available for review, there is indication that the medication is mildly improving the patient's pain from 8-9/10 to 6-7/10. However, there is no documentation in terms of specific examples of functional improvement, and no documentation regarding side effects. Furthermore, the last urine drug screen provided by the submitted documentation was completed more than one year ago in 6/2014. 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 (hydrocodone/acetaminophen) is not medically necessary.

Opana ER (extended release) 30mg, #80: 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 (Classification), Opioids, California Controlled Substance Utilization Review and Evaluation System (CURES) [DWC], Opioids, criteria for use, Opioids for chronic pain.

Decision rationale: Regarding the request for Opana ER (oxymorphone), Chronic Pain Medical Treatment Guidelines state that Opana ER 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 mildly improving the patient's pain from 8-9/10 to 6-7/10. However, there is no documentation in terms of specific examples of functional improvement, and no documentation regarding side effects. Furthermore, the last urine drug screen provided by the submitted documentation was completed more than one year ago in 6/2014. 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 Opana ER (oxymorphone) is not medically necessary.

Tizanidine HCL (hydrochloride) 2mg, #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): Muscle relaxants (for pain).

Decision rationale: Regarding the request for tizanidine (Zanaflex), Chronic Pain Medical Treatment Guidelines support the use of non-sedating muscle relaxants to be used with caution as a 2nd line option for the short-term treatment of acute exacerbations of pain. Guidelines go on to state that tizanidine specifically is FDA approved for management of spasticity; unlabeled use for low back pain. Guidelines recommend LFT monitoring at baseline, 1, 3, and 6 months. Within the documentation available for review, there is no identification appropriate liver function testing, as recommended by guidelines. Additionally, it does not appear that this medication is being prescribed for the short-term treatment of an acute exacerbation, as recommended by guidelines. This worker has long-standing chronic pain. Given this, the currently requested tizanidine (Zanaflex), is not medically necessary.

Gabapentin 300mg, #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): Anti-epilepsy drugs (AEDs).

Decision rationale: Regarding request for gabapentin, Chronic Pain Medical Treatment Guidelines state that anti-epilepsy drugs are recommended for neuropathic pain. They go on to state that a good outcome is defined as 50% reduction in pain and a moderate response is defined as 30% reduction in pain. Guidelines go on to state that after initiation of treatment, there should be documentation of pain relief and improvement in function as well as documentation of side effects incurred with use. The continued use of AEDs depends on improved outcomes versus tolerability of adverse effects. Within the documentation available for review, there is no identification of any specific objective functional improvement. Additionally, there is no discussion regarding side effects from this medication. In the absence of such documentation, the current request is not medically necessary.

Effexor XR (extended release) 150mg, #60: 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): Antidepressants for chronic pain.

Decision rationale: Regarding the request for venlafaxine (Effexor), guidelines state that antidepressants are recommended as a 1st line option for neuropathic pain and as a possibility for non-neuropathic pain. Guidelines go on to recommend a trial of at least 4 weeks. 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, and psychological assessment. Within the documentation available for review, there is no identification that the Effexor provides any objective functional improvement, reduction in opiate medication use, or improvement in psychological well-being. Given this, this request is not medically necessary.