MAXIMUS Federal Services

Case Number:	CM15-0207804		
Date Assigned:	10/26/2015	Date of Injury:	02/28/2003
Decision Date:	12/24/2015	UR Denial Date:	09/22/2015
Priority:	Standard	Application Received:	10/21/2015

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: New York
Certification(s)/Specialty: Anesthesiology

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 59 year old male, who sustained an industrial injury on 2-28-03. The injured worker was diagnosed as having lumbar spinal stenosis. Treatment to date has included status post lumbar microdiscectomy (8-6-09); status post right knee arthroscopy-menisectomy (9-17-09); Status post spinal cord stimulator implanted (7-6-11); physical therapy; TENS unit; epidural steroid injections; urine drug screenings; medications. Diagnostics studies included MRI lumbar spine. Currently, the PR-2 notes dated 9-3-15 indicated the injured worker has a history of chronic pain syndrome secondary to post laminectomy syndrome with radiculopathy with muscle spasms and knee pain. The provider notes the injured worker has undergone a right-sided L4-L5 laminectomy and discectomy in 2009 with no significant improvement in pain and radiculopathy. He also notes the injured worker has failed multiple conservative therapies including physical therapy, NSAIDS, TENS unit, various medication trials and epidural injections for greater than 6 months without or with short lived benefits. He continue to complain of low back pain with now worsening bilateral radicular pain, more pronounced on the right with tingling in the lower extremities. The provider notes the injured worker recently had a CAT scan of the lumbosacral spine for evaluation and will need to bring the results. Pain management continues to be managing the spinal cord stimulator as well as Norco, Norflex and Lyrica. He notes, "The patient continues to have difficulties obtaining Norco due to denial. Therefore continues to have difficulties with managing pain effectively and perform activities of daily living comfortably. Pain interrupts sleep which is now better managed with Lunesta. Norflex along with transdermal pain creams

are helpful in relieving muscular aches and muscle spasms." Lyrica helps manage the neuropathic pain presented as radiculopathy and pain associated with inflammation and swelling is now well managed with Voltaren. The provider is requesting refills authorization on these medications: Norflex 100mg, Lunesta 1mg and Voltaren XR 100mg. On PR-2 notes dated 8-6-15, 7-9-15, 6-11-15, 5-14-15, 4-16-15, 3-19-15 these same medications were prescribed to this injured worker. A Request for Authorization is dated 10-16-15. A Utilization Review letter is dated 9-22-15 and non-certification for Norflex 100mg #90; Lunesta 1mg #30; Norco 10-325mg #60 and Voltaren XR 100mg #60. A request for authorization has been received for Norflex 100mg #90; Lunesta 1mg #30; Norco 10-325mg #60 and Voltaren XR 100mg #60.

IMR ISSUES, DECISIONS AND RATIONALES

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

Norflex 100mg #90: Upheld

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

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

Decision rationale: According to the ODG, Norflex (Orphenadrine) is a muscle relaxant similar to diphenhydramine, but has greater anticholinergic effects. The mode of action is not clearly understood. Effects are thought to be secondary to analgesic and anticholinergic properties. According to CA MTUS guidelines, muscle relaxants are not considered any more effective than nonsteroidal anti-inflammatory drugs (NSAIDs) alone, and are not recommended for the long- term use of chronic pain. In this case, there is no documentation of a decrease in pain or muscle spasms, or any functional improvement from prior Norflex use. Based on the currently available information, the medical necessity for this muscle relaxant has not been established. The requested medication is not medically necessary.

Lunesta 1mg #30: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Chapter.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Insomnia treatment.

Decision rationale: Eszopicolone (Lunesta) is a prescription short-acting non-benzodiazepine sedative-hypnotic, which is recommended for short-term treatment of insomnia (two to six weeks). Benzodiazepine-receptor agonists work by selectively binding to type-1 benzodiazepine receptors in the CNS. Lunesta is indicated for the treatment of insomnia with difficulty of sleep onset and/or sleep maintenance. According to the ODG guidelines, non-Benzodiazepine

sedative-hypnotics are considered first-line medications for insomnia. All of the benzodiazepine-receptor agonists are schedule IV controlled substances, which have potential for abuse and dependency. It appears that the non-benzodiazepines have similar efficacy to the benzodiazepines with fewer side effects and short duration of action. Lunesta has demonstrated reduced sleep latency and sleep maintenance and is recommended for short-term use. In this case, Lunesta is a hypnotic and should not be used on a daily basis. Medical necessity for the requested medication has not been established. The requested item is not medically necessary.

Norco 10/325mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS General Approaches 2004, Section(s): General Approach to Initial Assessment and Documentation, and Chronic Pain Medical Treatment 2009, Section(s): Opioids for chronic pain, Opioids, criteria for use.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids for chronic pain. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Opioids.

Decision rationale: According to the CA MTUS and ODG, Norco 10/325mg (Hydrocodone/ Acetaminophen) is a short-acting opioid analgesic indicated for moderate to moderately severe pain, and is used to manage both acute and chronic pain. The treatment of chronic pain with any opioid analgesic requires review and documentation of pain relief, functional status, appropriate medication use, and side effects. A pain assessment should include current pain, intensity of pain after taking the opiate, and the duration of pain relief. In this case, there is insufficient evidence that the opioids were prescribed according to the CA MTUS guidelines, which recommend prescribing according to function, with specific functional goals, return to work, random drug testing, an opioid contract, and documentation of a prior failure of non- opioid therapy. There is no documentation of significant pain relief or increased functional benefit from the opioids used to date. Medical necessity of the requested medication has not been established. Of note, discontinuation of an opioid analgesic should include a taper to avoid withdrawal symptoms. The requested medication is not medically necessary.

Voltaren XR 100mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): NSAIDs (non-steriodal anti-inflammatory drugs).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): NSAIDs (non-steriodal anti-inflammatory drugs).

Decision rationale: Voltaren XR is a non-steroidal anti-inflammatory drug (NSAID). Oral NSAIDs are recommended for the treatment of chronic pain and control of inflammation as a second-line therapy after acetaminophen. The ODG states that NSAIDs are recommended for acute pain, osteoarthritis, acute pain and acute exacerbations of chronic pain. There is no evidence of long-term effectiveness for pain or function. There is inconsistent evidence for the use of NSAIDs to treat long-term neuropathic pain. Guidelines recommended that the

lowest effective dose be used for the shortest duration of time consistent with treatment goals. In this case, the patient had prior use of NSAIDs without any documentation of significant improvement. There was no documentation of subjective or objective functional improvement. Medical necessity of the requested medication has not been established. The requested Voltaren XR is not medically necessary.