

Case Number:	CM15-0020116		
Date Assigned:	02/09/2015	Date of Injury:	02/16/2011
Decision Date:	03/30/2015	UR Denial Date:	01/23/2015
Priority:	Standard	Application Received:	02/03/2015

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: Maryland, Texas, Virginia

Certification(s)/Specialty: Internal Medicine, Allergy and Immunology, Rheumatology

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 61 year old female, who sustained an industrial injury on 2/16/11. The injured worker has complaints of low back pain which extends in a band across the lower lumbar spine and radiated down the lateral aspect of the left lower extremity to ht knee and pain over both hips. The pain is aching, burning and sharp. She has tenderness in the midline of her lower spine. Range of motion of the lumbar spine is markedly reduced in all directions. The diagnoses have included degenerative disc disease, lumbar; neck pain and bilateral hip pain. The documentation noted that the injured worker had a trial with a spinal cord stimulator; implant stimulator; Computed Tomography (CT) scan of the lumbar spine that showed minimally displaced fracture of the right T1 transverse process post a fall out of bed post having the implant stimulator placed 11/8/12. She underwent a lumbar discogram that was positive at L4/5 andL5/S1. According to the utilization review performed on 1/23/15, the requested Percocet 10/325 #150; Trazaodone 50 mg #30 and Zanaflex 4 mg #120 has been non-certified. CA MTUS: Chronic Pain Medical Treatment Guidelines, Muscle relaxants (for Pain); Trazodone; ACOEM Guidelines, page 115, pain medications; Initial approaches to Treatment chapter 3, page 47-48 and Official Disability Guidelines pain chapter; opioids for chronic pain; Mental Illness and Stress Chapter; Insomnia Treatment were used in the utilization review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Percocet 10/325 #150: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment Page(s): 47-48, Chronic Pain Treatment Guidelines Opioids for chronic pain.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74-96. Decision based on Non-MTUS Citation Official Disability Guidelines Low Back - Lumbar & Thoracic (Acute & Chronic), Opioids

Decision rationale: Percocet (oxycodone with acetaminophen) is a short-acting opioid. Chronic pain guidelines and ODG do not recommend opioids except for short use for severe cases, not to exceed 2 weeks and Routine long-term opioid therapy is not recommended, and ODG recommends consideration of a one-month limit on opioids for new chronic non-malignant pain patients in most cases, as there is little research to support use. The research available does not support overall general effectiveness and indicates numerous adverse effects with long-term use. The latter includes the risk of ongoing psychological dependence with difficulty weaning. Medical documents indicate that the patient has been on Percocet in excess of the recommended 2-week limit. Additionally, indications for when opioids should be discontinued include if there is no overall improvement in function, unless there are extenuating circumstances. Medical records indicate that the overall pain level has increased over the last several months and there is lack of documentation of overall improvement in function, which are indications of when an opioid should be discontinued. As such, the request for Percocet 10/325 T PO Q 4-6 PRN Pain #150 is not medically necessary.

Trazaodone 50 mg #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, Mental illness and stress chapter, Antidepressants for treatment of MDD, Trazadone and Pain Chapter , Insomnia Treatment.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Mental Illness and Stress, Trazodone Mental Illness and Stress, Trazodone

Decision rationale: Regarding Trazodone, the above cited guidelines say: Recommended as an option for insomnia, only for patients with potentially coexisting mild psychiatric symptoms such as depression or anxiety. See also Insomnia treatment, where it says there is limited evidence to support its use for insomnia, but it may be an option in patients with coexisting depression. The current recommendation is to utilize a combined pharmacologic and psychological and behavior treatment when primary insomnia is diagnosed. Also worth noting, there has been no dose-finding study performed to assess the dose of trazodone for insomnia in non-depressed patients. Other pharmacologic therapies should be recommended for primary insomnia before considering trazodone, especially if the insomnia is not accompanied by

comorbid depression or recurrent treatment failure. There is no clear-cut evidence to recommend trazodone first line to treat primary insomnia. The employee has a history of depression and insomnia which are being treated with Wellbutrin. The records fail to demonstrate sleep hygiene discussion to assist with insomnia prior to medications. As such, the request for Trazadone 50mg T PO QHS #30 is not medically necessary.

Zanaflex 4 mg #120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants for pain.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants, Zanaflex Page(s): 63-67.

Decision rationale: Zanaflex is the brand name version of tizanidine, which is a muscle relaxant. MTUS states concerning muscle relaxants "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) (VanTulder, 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. Also 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) Sedation is the most commonly reported adverse effect of muscle relaxant medications. These drugs should be used with caution in patients driving motor vehicles or operating heavy machinery. Drugs with the most limited published evidence in terms of clinical effectiveness include chlorzoxazone, methocarbamol, dantrolene and baclofen. (Chou, 2004) According to a recent review in [REDACTED], skeletal muscle relaxants are the most widely prescribed drug class for musculoskeletal conditions (18.5% of prescriptions), and the most commonly prescribed antispasmodic agents are carisoprodol, cyclobenzaprine, metaxalone, and methocarbamol, but despite their popularity, skeletal muscle relaxants should not be the primary drug class of choice for musculoskeletal conditions. (See2, 2008). MTUS further states, Tizanidine (Zanaflex, generic available) is a centrally acting alpha2-adrenergic agonist that is FDA approved for management of spasticity; unlabeled use for low back pain. (Malanga, 2008) Eight studies have demonstrated efficacy for low back pain. (Chou, 2007) One study (conducted only in females) demonstrated a significant decrease in pain associated with chronic myofascial pain syndrome and the authors recommended its use as a first line option to treat myofascial pain. (Malanga, 2002) May also provide benefit as an adjunct treatment for fibromyalgia. (ICSI, 2007). As written, the prescription for Zanaflex is in excess of the two weeks recommended time period. Also, As such, the request for Zanaflex 4mg T-TT PO Q 12 PRN SPOM #120 is not medically necessary.