

Case Number:	CM15-0030103		
Date Assigned:	02/23/2015	Date of Injury:	06/02/2010
Decision Date:	04/13/2015	UR Denial Date:	02/10/2015
Priority:	Standard	Application Received:	02/18/2015

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: 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 47 year old female, who sustained an industrial injury on June 2, 2010. The diagnoses have included headaches, cervicgia, and major depressive disorder. Treatment to date has included acupuncture, cognitive behavioral therapy, and medications. Currently, the injured worker complains of pain in the head and neck with vertigo and headaches. The Primary Treating Physician's report dated January 23, 2015, noted that areas of pain and tenderness remained. On February 10, 2015, Utilization Review non-certified Naproxen 500mg #60, Zanaflex 4mg #90, Topamax 50mg #30, and Zofran 4mg #30, noting that there was a lack of evidence in the medical records to provide a complete and accurate pain assessment and the efficacy of the medications, and that based on the clinical information submitted and using the evidence based, peer reviewed guidelines the requests were non-certified. The MTUS Chronic Pain Medical Treatment Guidelines and the Official Disability Guidelines (ODG) were cited. On February 18, 2015, the injured worker submitted an application for IMR for review of Naproxen 500mg #60, Zanaflex 4mg #90, Topamax 50mg #30, and Zofran 4mg #30.

IMR ISSUES, DECISIONS AND RATIONALES

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

Naproxen 500mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): 67.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): 67-71. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) NSAIDs.

Decision rationale: Naproxen 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. ODG states that NSAIDs are recommended for acute pain, osteoarthritis, acute low back pain (LBP) and acute exacerbations of chronic LBP, short-term pain relief in chronic LBP, and short-term improvement of function in chronic LBP. 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 on NSAIDs without any documentation of significant improvement. There was no documentation of subjective or objective functional benefit from use of this medication. Medical necessity of the requested medication has not been established. The request for Naproxen is not medically necessary.

Zanaflex 4mg #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antispasticity/Antispasmodic Drugs Page(s): 66.

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

Decision rationale: Zanaflex (Tizanidine) is a centrally acting alpha2-adrenergic agonist that is FDA approved for management of spasticity; unlabeled use for low back pain. It is indicated for the treatment of chronic myofascial pain and considered an adjunct treatment for fibromyalgia. According to CA MTUS Guidelines, muscle relaxants have not been considered any more effective than non-steroidal anti-inflammatory drugs (NSAIDs) for pain or overall improvement. There is no additional benefit shown in combination with NSAIDs. In addition, sedation is the most commonly reported adverse effect of muscle relaxant medications. In this case, there is no documentation of any evidence of significant pain relief or objective functional improvement from use of Zanaflex. In addition, the guideline criteria do not support the long-term (>2 wks) use of muscle relaxants. Medical necessity for the requested medication has not been established. The requested medication, Zanaflex, is not medically necessary.

Topamax 50mg #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Other Antiepileptic Drugs Page(s): 21.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antiepilepsy drugs (AEDs) Page(s): 16-21. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Topiramate (Topamax).

Decision rationale: Topamax (Topiramate) is an anti-epilepsy drug (AED) used for the treatment of neuropathic pain. It has been shown to have variable efficacy, with failure to demonstrate efficacy in neuropathic pain of central etiology. It is still considered for use for neuropathic pain when other anticonvulsants fail. In this case, there is no documentation of neuropathic pain. There is no documentation of the any improvement in pain relief or functional benefit from the use of this medication. Medical necessity for the requested medication is not established. The requested medication is not medically necessary.

Zofran 4mg #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), Ondansetron (Zofran).

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

Decision rationale: Ondansetron is not recommended for nausea and vomiting secondary to chronic opioid use. This medication is recommended for acute use as noted per FDA-approved indications. In this case, the patient has been prescribed Zofran for >1 year. There was no documentation of the efficacy of this medication. There is no specific indication for the use of Ondansetron at this time. Medical necessity for the requested medication is not established. The requested medication is not medically necessary.