

Case Number:	CM15-0054918		
Date Assigned:	03/30/2015	Date of Injury:	06/28/2000
Decision Date:	05/06/2015	UR Denial Date:	02/26/2015
Priority:	Standard	Application Received:	03/23/2015

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: Massachusetts

Certification(s)/Specialty: Anesthesiology, 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 63 year old female who sustained an industrial injury on June 28, 2000. The injured worker is status post C4-5 and C5-C6 cervical fusion (no date documented) and lumbar surgery (no date documented). Recent diagnostic testing includes an Electromyography (EMG)/Nerve Conduction Velocity (NCV) in July 2013. The injured worker was diagnosed with cervical radiculopathy, status post cervical fusion, chronic pain, lumbar postlaminectomy syndrome, and lumbar radiculopathy, left ilioinguinal neuralgia, cervical dystonia, myoclonic neck spasms and gastro intestinal disturbances due to medications. According to the treating physician's progress report on February 3, 2015, the injured worker was re-examined for pain medication follow-up. The injured worker continues to experience neck pain radiating down both upper extremities with muscle weakness and frequent spasms in the neck area bilaterally. The low back pain radiates to the bilateral lower extremity with spasms. Examination of the cervical spine demonstrated tenderness to palpation with spasms bilaterally and limited range of motion. The injured worker's speech was hoarse and halting. She also complains of bilateral hand pain, fatigue and severe constipation. The injured worker received a B-12 injection at the office visit. Current medications are listed as Fentanyl Patches, Butalbital for headaches, Hydrocodone, Pantoprazole, Tizanidine, Naloxone Kit, Ativan, Trazodone, Zofran, Zoloft, Senokot, and vitamin supplementations. Treatment plan is to continue using the transcutaneous electrical nerve stimulation (TEN's) unit, orthopedic bed for elevation of the head and the current request for multiple prescribed medications and occupational therapy for cervical spasm and dystonia.

IMR ISSUES, DECISIONS AND RATIONALES

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

Occupational Therapy for severe restriction cervical range of motion/spasm and associated speech/swallowing difficulty: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical medicine Page(s): 98.

Decision rationale: Physical Medicine, pg 98, Physical Medicine is recommended as indicated below. Passive therapy (those treatment modalities that do not require energy expenditure on the part of the injured worker) can provide short term relief during the early phases of pain treatment and are directed at controlling symptoms such as pain, inflammation and swelling and to improve the rate of healing soft tissue injuries. They can be used sparingly with active therapies to help control swelling, pain and inflammation during the rehabilitation process. Active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. Active therapy requires an internal effort by the individual to complete a specific exercise or task. This form of therapy may require supervision from a therapist or medical provider such as verbal, visual and/or tactile instruction(s). Injured workers are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. Home exercise can include exercise with or without mechanical assistance or resistance and functional activities with assistive devices. (Colorado, 2002) (Airaksinen, 2006) Injured worker-specific hand therapy is very important in reducing swelling, decreasing pain, and improving range of motion in CRPS. (Li, 2005) The use of active treatment modalities (e.g., exercise, education, activity modification) instead of passive treatments is associated with substantially better clinical outcomes. In a large case series of injured workers with low back pain treated by physical therapists, those adhering to guidelines for active rather than passive treatments incurred fewer treatment visits, cost less, and had less pain and less disability. The overall success rates were 64.7% among those adhering to the active treatment recommendations versus 36.5% for passive treatment. (Fritz, 2007) Physical Medicine Guidelines "Allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home Physical Medicine. Myalgia and myositis, unspecified (ICD9 729.1): 9-10 visits over 8 weeks. Neuralgia, neuritis, and radiculitis, unspecified (ICD9 729.2) 8-10 visits over 4 weeks. Reflex sympathetic dystrophy (CRPS) (ICD9 337.2): 24 visits over 16 weeks. According to the documents available for review, the injured worker has previously undergone numerous sessions of PT without objective documented functional improvement. Further sessions of PT would be in contrast to the guidelines as set forth in the MTUS. Therefore, at this time, the requirements for treatment have not been met and medical necessity has not been established. The request is not medically necessary.

Fentanyl 25mcg patch; one (1) Q72hrs #10: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74-97.

Decision rationale: According to the MTUS Chronic Pain Medical Treatment Guidelines section on Opioids, On-Going Management, p 74-97, (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 injured worker'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 injured worker'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 injured workers 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 injured worker 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 injured worker 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 nonopioid 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. Additionally, the MTUS states that continued use of opioids requires (a) the injured worker has returned to work, (b) the injured worker has improved functioning and pain. There is current documentation of baseline pain, pain score with use of opioids, functional improvement on current regimen, side effects and review of potentially aberrant drug taking behaviors as outlined in the MTUS and as required for ongoing treatment. Therefore, at this time, the requirements for treatment have been met and medical necessity has been established. Therefore the request is medically necessary.

Butalbital/APAP/Caffeine 50-325-40mg; BID #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Barbiturate-containing analgesic agents (BCAs).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Pain (Chronic), Barbiturate Containing Analgesic Agents.

Decision rationale: The MTUS does not specifically comment on barbiturate containing analgesic agents such as fiorocet, therefore the Official Disability Guidelines were consultant. According to the ODG, barbiturate containing analgesic agents such as fiorocet, are not recommended for chronic pain. The potential for drug dependence is high and no evidence exists to show a clinically important enhancement of analgesic efficacy of BCAs due to the barbiturate constituents. (McLean, 2000) Fioricet is commonly used for acute headache, with some data to support it, but there is a risk of medication overuse as well as rebound headache. Therefore, at this time, the requirements for treatment have not been met and medical necessity has not been established. The request is not medically necessary.

Hydrocodone 10/325mg; one Q6hrs #115: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74-97.

Decision rationale: According to the MTUS Chronic Pain Medical Treatment Guidelines section on Opioids, On-Going Management, p 74-97, (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 injured worker'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 injured worker'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 injured workers 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 injured worker should be requested to keep a pain dairy 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 injured worker 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 nonopioid 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. Additionally, the MTUS states that continued use of opioids requires (a) the injured worker has returned to work, (b) the injured worker has improved functioning and pain. There is current documentation of baseline pain, pain score with use of opioids, functional improvement on current regimen, side effects and review of potentially aberrant drug taking behaviors as outlined in the MTUS and as required for ongoing treatment. Therefore, at this time, the requirements for treatment have been met and medical necessity has been established. The request is medically necessary.

Tizanidine 4mg; QID #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 Zanaflex Page(s): 63-66.

Decision rationale: According to the MTUS, 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) Side effects: somnolence, dizziness, dries mouth, hypotension, weakness, hepatotoxicity (LFTs should be monitored baseline, 1, 3, and 6 months). (See, 2008) Dosing: 4 mg initial dose; titrate gradually by 2-4 mg every 6-8 hours until therapeutic effect with tolerable side-effects; maximum 36 mg per day. (See, 2008) Use with caution in renal impairment; should be avoided in hepatic impairment. Tizanidine use has been associated with hepatic aminotransaminase elevations that are usually asymptomatic and reversible with discontinuation. The MTUS recommends non-sedating muscle relaxants with caution as a second-line option for short-term treatment of acute exacerbations in injured workers 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. Sedation is the most commonly reported adverse effect of muscle relaxant medications. These drugs should be used with caution in injured workers 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 American Family Physician, 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) According to the documents available for review, the injured worker has been utilizing zanaflex for long-term treatment of chronic pain condition. This is in contrast to the MTUS recommendations for short-term treatment of acute exacerbations. Therefore, at this time, the requirements for treatment have not been met and medical necessity has not been established. Therefore the request is not medically necessary.

Pantoprazole DR 20mg; BID #60: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines PPI
Page(s): 68-69.

Decision rationale: The MTUS makes the following recommendations for the use of proton pump inhibitors. Clinicians should weight the indications for NSAIDs against both GI and cardiovascular risk factors. Determine if the injured worker is at risk for gastrointestinal events: (1) age > 65 years; (2) history of peptic ulcer, GI bleeding or perforation; (3) concurrent use of ASA, corticosteroids, and/or an anticoagulant; or (4) high dose/multiple NSAID (e.g., NSAID + low-dose ASA). Recent studies tend to show that H. Pylori does not act synergistically with NSAIDS to develop gastroduodenal lesions. Recommendations Injured workers with no risk factor and no cardiovascular disease: Non-selective NSAIDs OK (e.g., ibuprofen, naproxen, etc.) Injured workers at intermediate risk for gastrointestinal events and no cardiovascular disease: (1) A non-selective NSAID with either a PPI (Proton Pump Inhibitor, for example, 20 mg omeprazole daily) or misoprostol (200g four times daily) or (2) a Cox-2 selective agent. Long-term PPI use (> 1 year) has been shown to increase the risk of hip fracture (adjusted odds ratio 1.44). Injured workers at high risk for gastrointestinal events with no cardiovascular disease: A Cox-2 selective agent plus a PPI if absolutely necessary. Injured workers at high risk of gastrointestinal events with cardiovascular disease: If GI risk is high the suggestion is for a low-dose Cox-2 plus low dose Aspirin (for cardioprotection) and a PPI. If cardiovascular risk is greater than GI risk the suggestion is naproxen plus low-dose aspirin plus a PPI. Cardiovascular disease: A non-pharmacological choice should be the first option in injured workers with cardiac risk factors. It is then suggested that acetaminophen or aspirin be used for short term needs. An opioid also remains a short-term alternative for analgesia. Major risk factors (recent MI, or coronary artery surgery, including recent stent placement): If NSAID therapy is necessary, the suggested treatment is naproxen plus low-dose aspirin plus a PPI. Mild to moderate risk factors: If long-term or high-dose therapy is required, full-dose naproxen (500 mg twice a day) appears to be the preferred choice of NSAID. If naproxen is ineffective, the suggested treatment is (1) the addition of aspirin to naproxen plus a PPI, or (2) a low-dose Cox-2 plus ASA. According to the records available for review the injured worker does meet the guidelines required for the use of this medication therefore, at this time, the requirements for treatment have been met and medical necessity has been established. Therefore the request is medically necessary.

Naloxone 0.4mg/1ml/Evzio Kit: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Naloxone.

Decision rationale: According to the ODG, Naloxone is recommended for the complete or partial reversal of opioid depression including respiratory depression induced by natural and synthetic opioids. There is no documentation or rationale presented that the Injured Worker is at risk for respiratory depression or had a prior episode of respiratory depression. Therefore, at this time, the requirements for treatment have not been met and medical necessity has not been established. Therefore the request is not medically necessary.