

Case Number:	CM15-0081071		
Date Assigned:	05/01/2015	Date of Injury:	07/02/2003
Decision Date:	06/25/2015	UR Denial Date:	04/16/2015
Priority:	Standard	Application Received:	04/27/2015

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 55-year-old male who sustained an industrial injury on 07/02/2003. Diagnoses include failed back surgery syndrome-lumbar, low back pain, lumbar radiculopathy, lumbar degenerative disc disease, myofascial pain syndrome, neck pain, cervical degenerative disc disease, cervical radiculopathy, failed back surgery syndrome-cervical, depression due to chronic pain, constipation secondary to pain medications-improved. Treatment to date has included diagnostic studies, medications, surgery, and home exercise program. A physician progress note dated 04/06/2015 documents the injured worker complains of ongoing low back pain with referral of the pain into the lower extremities. He also has neck pain but the low back pain is more severe. He uses a cane to walk, and has an antalgic gait. He reports his medications help his pain by approximately 50%. Cervical spine range of motion is restricted. Spurling test is positive. Range of motion of the shoulders, elbows and wrists are normal. There was tenderness to palpation over the cervical paraspinal muscles. Range of motion of the thoracolumbar spine restricted. Straight leg raise test is mildly positive bilaterally. The treatment plan included medication refills, discontinuation of Elavil, and a follow up in approximately 2 months. Treatment requested is for Amitiza 24 mcg, Qty 60 with 1 refill, Colace 250 mg, Qty 60 with 2 refills, Cymbalta 60 mg, Qty 30with 2 refills, MS (morphine sulfate) Contin 30 mg, Qty 60 with 2 refills, Neurontin 600 mg Qty 90, Percocet 10/325 mg, Qty 120 with 2 refills, and Zanaflex 4 mg, Qty 60 with 2 refills.

IMR ISSUES, DECISIONS AND RATIONALES

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

Neurontin 600 mg Qty 90: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Gabapentin (Neurontin) Page(s): 49.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-epilepsy drugs (AEDs) Page(s): 17-19.

Decision rationale: Neurontin (Gabapentin) is an anti-epilepsy drug, which has been shown to be effective for treatment of diabetic painful neuropathy and post-herpetic neuralgia and has been considered as a first-line treatment for neuropathic pain. The records document that the patient has reported radiculopathy related to his chronic low back condition, with evidence of neuropathic pain. There was documentation of objective findings consistent with current neuropathic pain to necessitate the use of Neurontin. Medical necessity for Neurontin has been established. The requested medication is medically necessary.

Percocet 10/325 mg, Qty 120 with 2 refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Oxycodone/acetaminophen (Percocet) Page(s): 92.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids for the treatment of chronic pain Page(s): 91-97.

Decision rationale: According to the CA MTUS and the ODG, Percocet (Oxycodone / Acetaminophen) is a short-acting opioid analgesic indicated for moderate to 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 no documentation of the medication's pain relief effectiveness, functional status, or response to ongoing opioid analgesic therapy. 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 treatment with Percocet 10/325 mg is not medically necessary.

MS (morphine sulfate) Contin 30 mg, Qty 60 with 2 refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Avinza (morphine sulfate); Opioids Page(s): 23; 124.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids for the treatment of chronic pain Page(s): 91-97. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Opioids.

Decision rationale: According to ODG and MTUS, MS Contin (Morphine Sulfate Controlled-Release) is a controlled-release preparation that should be reserved for patients with chronic pain, who are in need of continuous treatment. 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. For opioids, such as MS Contin, to be supported for longer than 6 months, there must be documentation of decreased pain levels and functional improvement. A satisfactory response to treatment may be indicated by decreased pain, increased level of function, and/or improved quality of life. In this case, there was no evidence of functional benefit or response to ongoing analgesic therapy to support continuation of this medication. Medical necessity of the requested medication has not been established. Of note, discontinuation of MS Contin should include a taper, to avoid withdrawal symptoms. The requested medication is not medically necessary.

Zanaflex 4 mg, Qty 60 with 2 refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Tizanidine (Zanaflex) 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 also 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, the patient has reported cervical spasm on physical exam. However, there is no indication for long-term treatment with Zanaflex. Medical necessity for the requested medication has not been established. Zanaflex is not medically necessary.

Cymbalta 60 mg, Qty 30with 2 refills: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Cymbalta (Duloxetine) Page(s): 42-43.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressants, SNRIs Page(s): 13, 15-16. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Cymbalta; Antidepressants for chronic pain.

Decision rationale: According to the California MTUS Guidelines, antidepressants are indicated for the treatment of chronic musculoskeletal pain. They are recommended as a first-line option for neuropathic pain, and as a possibility for non-neuropathic pain. Cymbalta

(Duloxetine) is a norepinephrine and serotonin reuptake inhibitor antidepressant (SNRI). It has FDA approval for treatment of depression, generalized anxiety disorder, and for the treatment of pain related to diabetic neuropathy. In this case, there is documentation of objective functional benefit with prior medication use. The medical necessity for Cymbalta has been established. The requested medication is medically necessary.

Colace 250 mg, Qty 60 with 2 refills: Overturned

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

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

Decision rationale: Opioid-induced constipation is a common adverse effect of long-term opioid use because of the binding of opioids to peripheral opioid receptors in the gastrointestinal tract, resulting in absorption of electrolytes and reduction in small intestine fluid. According to ODG, if opioids are determined to be appropriate for the treatment of pain then prophylactic treatment of constipation should be initiated. Colace is a stool softener used to relieve occasional constipation. According to the ODG, if opioids are determined to be appropriate for the treatment of pain then prophylactic treatment of constipation should be initiated. In this case, with opioid use, the medical necessity of Colace has been established. The requested medication is medically necessary.

Amitiza 24 mcg, Qty 60 with 1 refill: 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 (chronic) - Lubiprostone (Amitiza).

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

Decision rationale: Amitiza is recommended by the ODG as a second-line treatment for opioid induced constipation. Opioid-induced constipation is a common adverse effect of long-term opioid use because of the binding of opioids to peripheral opioid receptors in the gastrointestinal tract, resulting in absorption of electrolytes and reduction in small intestine fluid. According to the ODG, if opioids are determined to be appropriate for the treatment of pain then prophylactic treatment of constipation should be initiated. Given the non-approval of continued opioid therapy and the approval for Colace, there is no indication for continued therapy with Amitiza, which is a second-line treatment. Medical necessity for the medication has not been established. The requested medication is not medically necessary.