

<b>Case Number:</b>	CM14-0129865		
<b>Date Assigned:</b>	08/20/2014	<b>Date of Injury:</b>	03/27/2009
<b>Decision Date:</b>	10/16/2014	<b>UR Denial Date:</b>	08/11/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/14/2014

### 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. The expert reviewer is Board Certified in Physical Medicine and Rehabilitation and is licensed to practice in Nevada. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### 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 records presented for review indicate that this 56 year-old female was reportedly injured on March 27, 2009. The most recent progress note, dated September 3, 2014, indicates that there are ongoing complaints of low back pain rated 6/10. The physical examination demonstrated a front weaning (42) posture and requires a wheeled walker for ambulation. Motor function is introduction noted to be intact. Diagnostic imaging studies objectified changes consistent with the surgical intervention. Previous treatment includes multiple medications, physical therapy, lumbar fusion surgery, and pain management interventions. A request had been made for multiple medications and was not certified in the pre-authorization process on August 11, 2014.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Oxycontin 30mg, #90:** Upheld

**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): 75, 78, 92, 97.

**Decision rationale:** MTUS guidelines support long-acting opiates in the management of chronic pain when continuous around-the-clock analgesia is needed for an extended period of time.

Management of opiate medications should include the lowest possible dose to improve pain and function, as well as the ongoing review and documentation of pain relief, functional status, appropriate medication use and side effects. The claimant suffers from chronic pain; however, there is no documentation of improvement in their pain level or increased overall functionality with the current treatment regimen. In the absence of subjective or objective clinical data, this request is not considered medically necessary.

**Oxycodone 15mg, #120:** Upheld

**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): 75, 78, 92, 97.

**Decision rationale:** MTUS guidelines support long-acting opiates in the management of chronic pain when continuous around-the-clock analgesia is needed for an extended period of time. Management of opiate medications should include the lowest possible dose to improve pain and function, as well as the ongoing review and documentation of pain relief, functional status, appropriate medication use and side effects. The claimant suffers from chronic pain; however, there is no documentation of improvement in their pain level or increased overall functionality with the current treatment regimen. In the absence of subjective or objective clinical data, this request is not considered medically necessary.

**Amitriptyline 50mg, #30 (w/3 Refills):** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Anti-Depressant for Neuropathic Pain.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 13-15.

**Decision rationale:** MTUS guidelines support the use of tricyclic antidepressants in chronic pain management and consider tricyclics a first-line option in the treatment of neuropathic pain. Elavil (Amitriptyline) is a tricyclic antidepressant medication. As such, there is a clinical indication for this medication. However, with the number of refills there is a lack of objectification of patient compliance issue that mitigates the endorsement. As such, the request is not medically necessary.

**Prilosec 20mg, #60 (w/3 Refills):** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Proton-Pump Inhibitors.

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

**Decision rationale:** MTUS guidelines support the use of tricyclic antidepressants in chronic pain management and consider tricyclics a first-line option in the treatment of neuropathic pain. Elavil (Amitriptyline) is a tricyclic antidepressant medication. As such, there is a clinical indication for this medication. However, with the number of refills there is a lack of objectification of patient compliance issue that mitigates the endorsement. As such, the request is not medically necessary.

**Xanax 1mg, #90:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 24.

**Decision rationale:** As outlined in the MTUS, there is no support for chronic, indefinite or long-term use of benzodiazepines as the long-term efficacy is unproven and the side effect profile is significant. Therefore, when noting that the guidelines of this medication to approximately 4 weeks, there is insufficient clinical data presented to support the medical necessity of indefinite use.

**Zanaflex 2mg, #180:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Non-Sedating Muscle Relaxant.

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

**Decision rationale:** Zanaflex (Tizanidine) is a centrally acting alpha 2-adrenergic agonist that is FDA approved for management of spasticity. It is unlabeled for use in low back pain. Furthermore, muscle relaxants are only indicated as 2nd line options for short-term treatment. It appears that this medication is being used on a chronic, indefinite long-term basis which is not supported by MTUS treatment guidelines. Therefore, this medication is not medically necessary.

**Lyrica 75mg, #60 (w/3 Refills):** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 19, 99.

**Decision rationale:** As noted in the MTUS, this medication is indicated for diabetic neuropathy and postherpetic neuralgia. An off label use is neuropathic pain. However, when reviewing the

progress notes presented, there is no clinical indication that this medication is having any of its desired effect. Therefore the efficacy and utility of the continued use of this medication is not objectified in the progress notes presented. One cannot establish the medical necessity.