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| Case Number: | CM14-0132579 | | |
| Date Assigned: | 08/22/2014 | Date of Injury: | 11/04/1999 |
| Decision Date: | 09/24/2014 | UR Denial Date: | 08/04/2014 |
| Priority: | Standard | Application Received: | 08/19/2014 |

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 Pain Medicine and is licensed to practice in Texas and Oklahoma. 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 injured worker is a 66-year-old female with a reported date of injury on 11/04/1999. The mechanism of injury was not submitted within the medical records. Her diagnoses were noted to include cervical spondylosis with myelopathy, lumbosacral spondylosis without myelopathy, degenerative cervical intervertebral disc, degenerative lumbar/lumbosacral intervertebral disc, degenerative thoracic/thoracolumbar disc, cervicalgia, thoracic spine pain, lumbago, thoracic/lumbosacral neuritis/radiculitis, muscle spasms and myalgia and myositis. Her previous treatments were noted to include medications, physical therapy, a home exercise program, and epidural steroid injections. The progress note dated 05/20/2014 revealed complaints that the Ambien was not working well, and she had difficulty sleeping. The injured worker wanted to consider another sleeping aid. The injured worker indicated Zanaflex was not working well either, and the Vicodin 7.5/300 mg trial was not working. The injured worker indicated she had low back, neck, and shoulder pain and the low back was the worst area. Her medication regimen was noted to include Imitrex 20 mg 1 spray nasally as needed for migraines, Linzess 290 mcg capsule 1 every other day as needed, Zanaflex 4 mg 1 at bedtime as needed. The physical examination revealed no signs of sedation or withdrawal. The injured worker continued to complain of ongoing baseline pain in the spine with shoulder pain and knee pain as well as myofascial pain syndrome. The injured worker continued to have cervical, thoracic, and lumbar pain complaints with diffuse symptoms. There were no neurological deficits. The physical examination was essentially unchanged. The Request for Authorization form was not submitted within the medical records. The request was for Zanaflex for muscle spasms, Imitrex nasal spray #6 bottle for migraine headaches, Relpax 40 mg daily as needed #9, Neural cream via Drug Depot #1, Voltaren gel samples, however, the provider's rationale was not submitted within the

medical records. The request was for Vicodin 5/300 four times daily #60 for back and thoracic pain.

IMR ISSUES, DECISIONS AND RATIONALES

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

Zanaflex: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxant. Decision based on Non-MTUS Citation Official Disability Guideline (ODG).

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

Decision rationale: The request for Zanaflex is not medically necessary. The injured worker has been utilizing Zanaflex since at least 01/2014. The California Chronic Pain Medical Treatment Guidelines recommend muscle relaxants as a second line option for the short term treatment of acute low back pain and their use is recommended for less than 3 weeks. There should be documentation of objective functional improvement. The clinical documentation submitted for review does provide evidence that the injured worker has been on this medication for an extended duration of time, and there is a lack of documentation of objective improvement. The injured worker indicated the Zanaflex was not working well. Additionally, the request failed to provide the dosage and frequency at which this medication is to be utilized. Therefore, the request is not medically necessary.

Imitrex nasal spray #6 bottle: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guideline (ODG) Treatment Workers Compensation (TWC).

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

Decision rationale: The request for Imitrex nasal spray #6 bottle is not medically necessary. The injured worker has been utilizing this medication since at least 01/2014. The Official Disability Guidelines recommend triptans for migraine sufferers. At marketed doses, all oral triptans are effective and well tolerated. Differences among them are generally relatively small, but clinically relevant for individual patients. A poor response to 1 triptan does not predict a poor response to other agents in this class. Rizatriptan has demonstrated in a head to head study, high response rates and a more rapid onset of action than Sumatriptan, together with a favorable tolerability profile. Meta-analysis after low blind placebo controlled studies has confirmed the superior efficacy of Rizatriptan. There is a lack of documentation regarding migraine headaches to warrant Imitrex. There is a lack of documentation regarding efficacy of this medication and the request failed to provide the frequency at which this medication is to be utilized. Therefore, the request is not medically necessary.

Relpax 40mg daily as needed #9: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guideline (ODG) Treatment Workers Compensation (TWC).

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

Decision rationale: Request for Relpax 40 mg daily as needed #9 is not medically necessary. The Official Disability Guidelines recommend triptans for migraine sufferers. At marketed doses, all oral triptans are effective and well tolerated. Differences among them are generally relatively small, but clinically relevant for individual patients. A poor response to 1 triptan does not predict a poor response to other agents in this class. Rizatriptan has demonstrated in a head to head study, high response rates and a more rapid onset of action than Sumatriptan, together with a favorable tolerability profile. Meta-analysis after low blind placebo controlled studies has confirmed the superior efficacy of Rizatriptan. There is a lack of documentation regarding migraine headaches to warrant Relpax. There is a lack of documentation regarding efficacy of this medication and the request failed to provide the frequency at which this medication is to be utilized. Therefore, the request is not medically necessary.

Neuro cream via drug depot #1: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111.

Decision rationale: The request for Neuro cream via Drug Depot #1 is not medically necessary. The injured worker complains of muscle tenderness and spasms. The California Chronic Pain Medical Treatment Guidelines indicate that topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. Topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Any compounded product that contains at least 1 drug (or drug class) that is not recommended, is not recommended. The request failed to provide the components for the Neuro cream to make a determination. Additionally, the request failed to provide the frequency at which this medication is to be utilized. Therefore, the request is not medically necessary.

Vicodin 5/300 4 times daily #60: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, On-going Management Page(s): 78.

Decision rationale: The request for Vicodin 5/300 at 4 times daily #60 is not medically necessary. The injured worker has been on opioids since at least 01/2014. According to the California MTUS Chronic Pain Medical Treatment Guidelines, the ongoing use of opioid medications may be supported with detailed documentation of pain relief, functional status, appropriate medication use, and side effects. The guidelines also state that the 4 As for ongoing monitoring (including analgesia, activities of daily living, adverse side effects, and aberrant drug-taking behaviors) should be addressed. There is a lack of documentation with evidence of decreased pain on a numerical scale with the use of medications. There is a lack of documentation of improved functional status with activities of daily living with the use of medications. There is a lack of documentation regarding side effects and without details regarding consistent urine drug screens and when the last test was performed, the ongoing use of opioid medications is not supported by the guidelines. Therefore, the request is not medically necessary.

Voltaren Gel- Samples: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics. Decision based on Non-MTUS Citation Official Disability Guideline (ODG) Treatment Workers Compensation (TWC) Pain.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-112.

Decision rationale: The request for Voltaren gel samples is not medically necessary. The injured worker complained of low back, neck, and shoulder pain. The California MTUS Chronic Pain Medical Treatment Guidelines indicate topical analgesics are largely experimental in use with few randomized control trials to determine efficacy or safety. Topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Any compounded product that contains at least 1 drug (or drug class) that is not recommended, is not recommended. The guidelines indicate that topical NSAIDs are recommended for short-term use (4 to 12 weeks). There is little evidence to utilize topical NSAIDs for treatment of osteoarthritis of the spine, hip, or shoulder. The FDA-approved agent as a topical NSAID is Voltaren gel 1% that is indicated for the relief of osteoarthritis pain in joints that lend themselves to topical treatment (ankle, elbow, foot, hand, knee, and wrist). It has not been evaluated for the treatment of the spine, hip, or shoulder. There is a lack of documentation regarding a diagnosis of osteoarthritis to warrant topical NSAIDs. The injured worker complained of pain to the spine, shoulder, and knee; however, without a diagnosis of osteoarthritis, the Voltaren gel is not appropriate at this time. Additionally, the request failed to provide the frequency at which this medication is to be utilized. Therefore, the request is not medically necessary.