

Case Number:	CM14-0144339		
Date Assigned:	09/12/2014	Date of Injury:	01/23/2003
Decision Date:	10/31/2014	UR Denial Date:	08/21/2014
Priority:	Standard	Application Received:	09/05/2014

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 Internal Medicine, has a subspecialty in Nephrology and is licensed to practice in California. 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:

This is a 36-year-old female with a 1/23/03 date of injury; the mechanism of the injury was not described. The patient was seen on 8/12/14 with complaints of the neck pain radiating down into the right upper extremity and associated numbness. The pain was rated 8/10 without medications and 4/10 with medications. The patient also reported low back pain radiating down into the right lower extremity. The pain was rated 9/10 without medications and 5/10 with medications. Exam findings revealed tenderness to palpation and spasm of the paravertebral muscles. The diagnosis is lumbago, lumbosacral spondylitis, cervicgia, cervicocranial syndrome, and internal derangement of the knee. Treatment to date: L3-S1 radiofrequency ablation on 9/12/12, epidural injections, work restrictions and medications. An adverse determination was received on 8/21/14. The request for Norco 10/325mg #90 was modified to #30 to initiate a weaning process. There was a lack of documentation indicating functional improvement from the previous usage of Norco. The request for Zanaflex 4mg #60 was denied given that there was a lack of documentation indicating spasm relief and there was no documentation contraindicating the use of NSAIDs for the patient's current condition. The request for Prilosec 20 mg #60 was denied given that there was no documentation of the patient's gastrointestinal (GI) distress symptoms and /or GI risk factors. The request for Restoril 30mg #30 was denied due to a lack of documented medical indication for that medication and there was a lack of documentation of derived symptomatic of functional improvement from its previous use.

IMR ISSUES, DECISIONS AND RATIONALES

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

Norco 10/325mg #90: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opiates Page(s): 78-81.

Decision rationale: CA MTUS Chronic Pain Medical Treatment Guidelines do not support ongoing opioid treatment unless prescriptions are from a single practitioner and are taken as directed; are prescribed at the lowest possible dose; and unless there is ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. The progress notes indicated, that the patient was utilizing Norco at least from 1/14/14 however, given the 2003 date of injury, the duration of opiate use to date is not clear. There is no discussion regarding non-opiate means of pain control, or endpoints of treatment. The records do not clearly reflect continued functional benefit, a lack of adverse side effects, or aberrant behavior. In addition, the UR decision dated 8/21/14 certified 30 tablets of Norco to initiate a weaning process. Non-certification here does not imply abrupt cessation for a patient who may be at risk for withdrawal symptoms. Should the missing criteria necessary to support the medical necessity of this request remain unavailable, discontinuance should include a tapering prior to discontinuing avoiding withdrawal symptoms. Therefore, the request for Norco 10/325mg #90 was not medically necessary.

Zanaflex 4mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM,Chronic Pain Treatment Guidelines Non-Sedating Muscle Relaxants.

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

Decision rationale: CA MTUS Chronic Pain Medical Treatment Guidelines, state that 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, and no additional benefit has been shown when muscle relaxants are used in combination with NSAIDs. Efficacy appears to diminish over time, and prolonged use of some medications in this class may lead to dependence. CA MTUS Chronic Pain Medical Treatment Guidelines state that Tizanidine is a centrally acting alpha2-adrenergic agonist that is FDA approved for management of spasticity and off label use for low back pain. In addition, MTUS also states that 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. The progress notes indicated, that the patient was utilizing Zanaflex at least from 1/14/14 however, given the 2003 date of injury, the duration of muscle

relaxant use to date is not clear. There is a lack of documentation indicating subjective and objective functional gains from the treatment with Zanaflex. There is no discussion with regards to the improvement in muscle spasms and there is no rationale indicating the necessity of long-term treatment with a muscle relaxant. In addition, the Guidelines do not support long-term treatment with muscle relaxants. Therefore, the request for Zanaflex 4mg #60 was not medically necessary.

Prilosec 20mg #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 68. Decision based on Non-MTUS Citation FDA (Prilosec)

Decision rationale: CA MTUS and the FDA support proton pump inhibitors in the treatment of patients with GI disorders such as: gastric/duodenal ulcers, GERD, erosive esophagitis, or patients utilizing chronic NSAID therapy. Prilosec is a proton pump inhibitor, PPI, used in treating reflux esophagitis and peptic ulcer disease. The progress notes indicated that the patient was utilizing Prilosec at least from 1/14/14 however; there is a lack of documentation indicating that the patient suffered from gastric or duodenal ulcer, erosive esophagitis or that the patient was chronically utilizing NSAIDs. In addition, there is no comment that relates the need for the proton pump inhibitor for treating gastric symptoms associated with the medications used in treating this industrial injury. In general, the use of a PPI should be limited to the recognized indications and used at the lowest dose for the shortest possible amount of time. Therefore, the request for Prilosec 20mg #60 was not medically necessary.

Restoril 30mg #30: Upheld

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

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

Decision rationale: CA MTUS Chronic Pain Medical Treatment Guidelines state that benzodiazepines range of action includes sedative/hypnotic, anxiolytic, anticonvulsant, and muscle relaxant. They are not recommended for long-term use because long-term efficacy is unproven and there is a risk of dependence. The progress notes indicated that the patient was utilizing Restoril at least from 1/14/14 however; there is a lack of documentation indicating any subjective and objective functional gains from the treatment with Restoril. There is no rationale with regards to the necessity for the long-term treatment with this medication given, that the patient was utilizing it for exceeded time due to the Guidelines. Therefore, the request for Restoril 30mg #30 was not medically necessary.