

Case Number:	CM14-0177953		
Date Assigned:	10/31/2014	Date of Injury:	06/23/2010
Decision Date:	12/08/2014	UR Denial Date:	10/13/2014
Priority:	Standard	Application Received:	10/27/2014

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 Preventive Medicine, has a subspecialty in Occupational Medicine and is licensed to practice in Iowa. 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 patient is a 47 year old with date of injury 6/23/2010. Medical records indicate the patient is undergoing treatment for left L5 radiculopathy, L5-S1 spondylolisthesis, grade 1, L5-S1 lateral recess stenosis, right cervical radiculopathy, C5-6 stenosis and disc herniation, S/P L5-S1 TLIF 11/10/11, and S/P left L5 foraminotomy and L4-L5 laminectomy 9/2/2012. Subjective complaints include worsening neck pain radiating to bilateral trapezius muscles; Pain and numbness radiating down right arm 10/10 and worsening headaches. pain and numbness with aching sensation to buttock and radiating down left lower extremity to plantar aspect of foot is rated 10/10. Patient also reports worsening constipation, anxiety, and panic attacks. Objective findings include examination of cervical spine and upper extremities revealing no gross deformity and no noted swelling. Cervical lordosis well maintained. Tenderness over bilateral paracervical muscles, tenderness to base of neck, base of skull, and trapezius musculature bilaterally; decreased sensation over right C6, C7, and C8 distributions; decreased cervical range of motion; negative Hoffman's, normal motor exam. Examination of lumbar spine reveals no gross deformity or swelling. Tenderness to lower lumbar spine upon palpation, tenderness to left sacroiliac joint and tenderness over left sciatic notch;. decreased sensation over left L3, L5, and S1 distribution; decreased lumbar range of motion, MRI of lumbar spine 4/14/14 shows L5-S1 S/P laminectomy and facetectomy with interbody fusion and pedicle screw fixation; normal alignment at surgical level; intercanal stenosis at L4-L5 (stable), and L5-S1 normal post-op changes. Treatment has consisted of surgeries mentioned above, TENS unit, cortisone injection to left hip, injection to left knee, and medications including Cymbalta, Ambien, Zanaflex, Motrin, Xanax, Amitiza, and Norco. The utilization review determination was rendered on 10/13/14 recommending non-certification of Xanax .5mg #60, Zanaflex 4mg #90, Ambien 10mg #30, and Butrans Patch 10mg #4.

IMR ISSUES, DECISIONS AND RATIONALES

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

Xanax .5mg #60: 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: MTUS states that benzodiazepine (i.e. Xanax) is "Not recommended for long-term use because long-term efficacy is unproven and there is a risk of dependence. Most guidelines limit use to 4 weeks. Their range of action includes sedative/hypnotic, anxiolytic, anticonvulsant, and muscle relaxant. Chronic benzodiazepines are the treatment of choice in very few conditions. Tolerance to hypnotic effects develops rapidly. Tolerance to anxiolytic effects occurs within months and long-term use may actually increase anxiety. A more appropriate treatment for anxiety disorder is an antidepressant. Tolerance to anti-convulsant and muscle relaxant effects occurs within weeks." Medical records indicate that the patient has been on Xanax in excess of MTUS guideline recommendations. The medical record does not provide any extenuating circumstances to recommend exceeding the guideline recommendations. Additionally, no documentation as to if a trial of antidepressants was initiated and the outcome of this trial and there is no documentation of intended duration of this therapy. As such, the request for Xanax .5mg #60 is not medically necessary.

Zanaflex 4mg #90: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants, Zanaflex Page(s): 63-67.

Decision rationale: Zanaflex is a muscle relaxant. MTUS states concerning muscle relaxants "Recommend non-sedating muscle relaxants with caution as a second-line option for short-term treatment of acute exacerbations in patients with chronic low back pain (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. (Homik, 2004) Sedation is the most commonly reported adverse effect of muscle relaxant medications. These drugs should be used with caution in patients 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). "MTUS further states, "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)." Zanaflex is a short term medication and the patient has been on this medication beyond the guideline recommendations. In addition the treatment physician does not detail functional improvement while on Zanaflex and has not provided a medical rationale to exceed guidelines. As such, the request for Zanaflex 4mg #90 is not medically necessary.

Ambien 10mg #30: Upheld

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

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

Decision rationale: The CA MTUS is silent regarding this topic. ODG states that Zolpidem is a prescription short acting non-benzodiazepine hypnotic, which is approved for short-term treatment of insomnia. In this case, the patient has been taking this medication as early as March 2013. There has been no discussion of the patient's sleep hygiene or the need for variance from the guidelines, such as "a) Wake at the same time every day; (b) Maintain a consistent bedtime; (c) Exercise regularly (not within 2 to 4 hours of bedtime); (d) Perform relaxing activities before bedtime; (e) Keep your bedroom quiet and cool; (f) Do not watch the clock; (g) Avoid caffeine and nicotine for at least six hours before bed; (h) Only drink in moderation; & (i) Avoid napping." Medical documents also do not include results of these first line treatments, if they were used in treatment of the patient's insomnia. ODG additionally states "The specific component of insomnia should be addressed: (a) Sleep onset; (b) Sleep maintenance; (c) Sleep quality; & (d) Next-day functioning." Medical documents provided do not detail these components. As such, the request for Ambien 10mg #30 is not medically necessary at this time.

Butrans Patch 10mg #4: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation FDA, www.drugs.com

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Buprenorphine Page(s): 26-27. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chronic Pain, Butrans

Decision rationale: ODG states "Buprenorphine transdermal system (Butrans; no generics): FDA-approved for moderate to severe chronic pain. Available as transdermal patches at 5mcg/hr., 10mcg/hr. and 20mcg/hr. See also Buprenorphine for treatment of opioid dependence."Buprenorphine is "recommended for treatment of opiate addiction. Also is recommended as an option for chronic pain, especially after detoxification in patients who have a history of opiate addiction." The ODG states that Buprenorphine is "recommended as an option for treatment of chronic pain (consensus based) in selected patients (not first-line for all patients). Suggested populations: (1) Patients with a hyperalgesic component to pain; (2) Patients with centrally mediated pain; (3) Patients with neuropathic pain; (4) Patients at high-risk of non-adherence with standard opioid maintenance; (5) For analgesia in patients who have previously been detoxified from other high-dose opioids. Use for pain with formulations other than Butrans is off-label. Due to complexity of induction and treatment the drug should be reserved for use by clinicians with experience."The employee is using this medication for chronic pain. However, there is no medical documentation of any of the five conditions listed above which are the specific indications for using Buprenorphine instead of one of the first line agents. As such, the request for Butrans Patch 10mg #4 is not medically necessary.