

Case Number:	CM14-0212558		
Date Assigned:	12/29/2014	Date of Injury:	06/11/1997
Decision Date:	02/19/2015	UR Denial Date:	11/18/2014
Priority:	Standard	Application Received:	12/18/2014

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. 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: California, Florida, Texas
 Certification(s)/Specialty: Internal Medicine, Occupational Medicine

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

According to the records made available for review, this is a 54-year-old female with a 6/11/97 date of injury. At the time (10/28/14) of the request for authorization for Zanaflex 4mg, SIG: 1 po Q4H prn spasms Quantity: 120 Refills: 5; Topical Fentanyl 100mcg/hr patch SIG: 1 to CW Q 2 days Quantity: 15 Refills: 1; and Narcotic Percocet 10/325mg tablet SIG: 1-2 PO Q4H prn BTP Quantity: 150 Refills: 1, there is documentation of subjective (ongoing difficulty with pain and spasms across her low back and in the left lower extremity) and objective (restricted painful movement of the lumbar spine, limited secondary to pain) findings, current diagnoses (status post anterior-posterior corpectomy and fusion, L3-4, L4-5, and L5-S1, with anterior plate fixation at L3-4 and L4-5; status post abdominal hernia repair; status post prior laminectomy, L5-S1, 1988, and chronic pain syndrome), and treatment to date (medication including ongoing use of Zanaflex, Fentanyl, and Percocet). Medical reports identify medications decrease pain and allow her to continue working, she denies negative side effects, no aberrant drug behaviors and she uses the medications as prescribed, prescriptions are from a single practitioner and are taken as directed, and the lowest possible dose is being prescribed and there will be ongoing review. Regarding Zanaflex 4mg, SIG: 1 po Q4H prn spasms Quantity: 120 Refills: 5, there is no documentation of spasticity and intended short-term treatment. Regarding Topical Fentanyl 100mcg/hr patch SIG: 1 to CW Q 2 days Quantity: 15 Refills: 1, there is no documentation that the patient requires continuous opioid analgesia for pain that cannot be managed by other means.

IMR ISSUES, DECISIONS AND RATIONALES

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

Zanaflex 4mg, 1 by mouth every 4 hours as needed for spasms Quantity: 120 Refills: 5:
Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antispasticity/Antispasmodic Drugs (Tizanidine (Zanaflex)) Page(s): 66. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Muscle relaxants (for pain); Other Medical Treatment Guideline or Medical Evidence: Title 8, California Code of Regulations, section 9792.20

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines identifies documentation of spasticity, as criteria necessary to support the medical necessity of Zanaflex. MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. ODG identifies that muscle relaxants are recommended as a second line option for short-term (less than two weeks) treatment of acute low back pain and for short-term treatment of acute exacerbations in patients with chronic low back pain. Within the medical information available for review, there is documentation of diagnoses of status post anterior-posterior corpectomy and fusion, L3-4, L4-5, and L5-S1, with anterior plate fixation at L3-4 and L4-5; status post abdominal hernia repair; status post prior laminectomy, L5-S1, 1988, and chronic pain syndrome. In addition, given documentation that medications decrease pain and allow her to continue working, there is documentation of functional benefit as a result of Zanaflex use to date. However, there is no documentation of spasticity. In addition, given documentation of ongoing treatment with Zanaflex, there is no documentation of intended short-term treatment. Therefore, based on guidelines and a review of the evidence, the request for Zanaflex 4mg, 1 by mouth every 4 hours as needed for spasms Quantity: 120 Refills: 5 is not medically necessary.

Topical Fentanyl 100mcg/hr patch 1 to CW every 2 days Quantity: 15 Refills: 1: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids for chronic pain Page(s): 80-81.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Duragesic (fentanyl transdermal system) Page(s): 44. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Duragesic and Fentanyl; Other Medical Treatment Guideline or Medical Evidence: Title 8, California Code of Regulations, section 9792.20; and FDA

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines identifies documentation of chronic pain in patients who require continuous opioid analgesia for pain that cannot be managed by other means, as criteria necessary to support the medical necessity of Duragesic. MTUS Chronic Pain Medical Treatment Guidelines identifies that Duragesic is not

recommended as first-line therapy. MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. ODG identifies documentation that Duragesic is not for use in routine musculoskeletal pain. FDA identifies documentation of persistent, moderate to severe chronic pain that requires continuous, around-the-clock opioid administration for an extended period of time, and cannot be managed by other means; that the patient is already receiving opioid therapy, has demonstrated opioid tolerance, and requires a total daily dose at least equivalent to Duragesic 25mcg/h; and no contraindications exist, as criteria necessary to support the medical necessity of Duragesic patch. Within the medical information available for review, there is documentation of diagnoses of status post anterior-posterior corpectomy and fusion, L3-4, L4-5, and L5-S1, with anterior plate fixation at L3-4 and L4-5; status post abdominal hernia repair; status post prior laminectomy, L5-S1, 1988, and chronic pain syndrome. In addition, there is documentation that the patient requires a total daily dose at least equivalent to Duragesic 25mcg/h. Furthermore, given documentation that medications decrease pain and allow her to continue working, there is documentation of functional benefit as a result of Fentanyl use to date. However, there is no documentation that the patient requires continuous opioid analgesia for pain that cannot be managed by other means. Therefore, based on guidelines and a review of the evidence, the request for Topical Fentanyl 100mcg/hr patch 1 to CW every 2 days Quantity: 15 Refills: 1 is not medically necessary.

Percocet 10/325mg tablet 1-2 by mouth every 4 hours as needed BTP Quantity: 150:

Overtuned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids for chronic pain Page(s): 80-81.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74-80. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Title 8, California Code of Regulations, section 9792.20

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines necessitate documentation that the prescriptions are from a single practitioner and are taken as directed; the lowest possible dose is being prescribed; and there will be ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects, as criteria necessary to support the medical necessity of opioids. MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. Within the medical information available for review, there is documentation of diagnoses of status post anterior-posterior corpectomy and fusion, L3-4, L4-5, and L5-S1, with anterior plate fixation at L3-4 and L4-5; status post abdominal hernia repair; status post prior laminectomy, L5-S1, 1988, and chronic pain syndrome. In addition, there is documentation that the prescriptions are from a single practitioner and are taken as directed; the lowest possible dose is being prescribed; and there will be ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. Furthermore, given documentation that medications decrease pain and allow her to continue working, there is

documentation of functional benefit as a result of Percocet use to date. Therefore, based on guidelines and a review of the evidence, the request for Percocet 10/325mg tablet 1-2 by mouth every 4 hours as needed BTP Quantity: 150 Refills: 1 is medically necessary.