

<b>Case Number:</b>	CM15-0001671		
<b>Date Assigned:</b>	02/06/2015	<b>Date of Injury:</b>	09/27/2001
<b>Decision Date:</b>	07/29/2015	<b>UR Denial Date:</b>	12/30/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/05/2015

### 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: New York

Certification(s)/Specialty: Anesthesiology

### 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 56 year old female who sustained an industrial injury on 9/27/01 with current chief complaints of chronic low back pain, left leg pain, cervical spine pain, and left arm pain. Diagnoses are post laminectomy syndrome lumbar region, lumbago, post laminectomy syndrome cervical region, injury to lumbar nerve root, thoracic/lumbosacral neuritis/radiculitis unspecified, spasm of muscle, and degeneration of lumbar/lumbosacral intervertebral disc. In a re-evaluation/follow up progress note dated 12/17/14, the treating physician notes she began having swelling and stiffness of her hands for 3 weeks. She complains of feeling a pinch and cramps in the low back and for the past 2 months, has a burning sensation in her neck which radiates down into the shoulders. MS Contin and Norco help her function well, and she has been using more Norco due to increased pain. She ran out of Norco 5 days prior. She complains of poor quality of sleep. Zanaflex and Ambien in combination help with sleep. Everything hurts but the back is the worst. She is getting tolerant to Norco and a trial of Percocet for breakthrough pain was discussed. Average pain since the previous visit of 10/22/14 is rated as 7 out of 10, mood as 8 out of 10 and functional level at 7 out of 10. She denies diarrhea or constipation. On exam, she notes ongoing severe low back pain and leg cramping and neck pain to hands bilaterally. She has lesions above her fusion of L4/5/S1 fusion for which she is surgical. She has mainly axial low back pain above her fusion. The current assessment is chronic low back pain and left leg pain, status post L4-L5 and L5-S1 fusion, failing L2-L3 and L3-L4 level, myofascial pain/spasm, hypothyroidism, poor sleep due to pain, and history of cervical spine fusion- stable. Medications that have been tried and failed previously are Fentanyl patch, Baclofen, Lyrica, and

Gralise. A repeat urine drug screening was done 12/14/14 and is noted as results are consistent. MRI of the cervical spine was done 11/11/13, and of the lumbar spine was done 10/3/12. Work status is that she is on disability. The treatment plan is to recommend regular home exercise /physical therapy on an ongoing basis, follow-up regarding pending surgical options, bilateral lumbar medial branch block, consider further injection therapy if refractory, lumbar MRI and surgical care, and medications. The treatment requested is Norco 10/325 mg, quantity 120, 0 refills, MS Contin 30 mg, quantity 60, 0 refills, Lorzone 750 mg, quantity 60, 0 refills, Ambien 10mg, quantity 30, 0 refills, Xanax 0.25 mg, quantity 60, 0 refills, Zanaflex 4 mg, quantity 60, 0 refills, Percocet 10/325 mg, quantity 30, 0 refills, Linzess 145 ugm, quantity 30, 0 refills.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**Norco 10/325mg qty: 120 refills: 0: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids for the treatment of chronic pain Page(s): 91-97. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Opioids.

**Decision rationale:** According to MTUS and the ODG, Norco10/325mg (Hydrocodone/Acetaminophen) is a short-acting opioid analgesic indicated for moderate to moderately severe pain, and is used to manage both acute and chronic pain. The benefits obtained from short acting narcotics diminishes over time and guideline recommend that there be ongoing indications of functional benefit and pain reduction to support continuing use of this medication. The treatment of chronic pain with any opioid analgesic requires review and documentation of pain relief, functional status, appropriate medication use, and side effects. A pain assessment should include current pain, intensity of pain after taking the opiate, and the duration of pain relief. In this case, there is mention of subjective evidence of response to ongoing analgesic therapy, however, no significant objective functional improvement to support continuation of this medication. In addition, there is insufficient evidence in the clinical literature that long term use of narcotic medications results in any functional improvement. Medical necessity of the requested item has not been established. Of note, discontinuation of an opioid analgesic should include a taper, to avoid withdrawal symptoms. The requested medication is not medically necessary.

**Ms Contin 30mg qty: 60 refills 0: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids for the treatment of chronic pain Page(s): 91-97.

**Decision rationale:** According to the ODG and MTUS, MS Contin (Morphine Sulfate Controlled-Release) is a controlled-release preparation that should be reserved for patients with chronic pain, who are in need of continuous treatment. The treatment of chronic pain with any opioid analgesic requires review and documentation of pain relief, functional status, appropriate medication use, and side effects. A pain assessment should include current pain, intensity of pain after taking the opiate, and the duration of pain relief. For opioids, such as MS Contin, to be supported for longer than 6 months, there must be documentation of decreased pain levels and functional improvement. A satisfactory response to treatment may be indicated by decreased pain, increased level of function, and/or improved quality of life. In this case, there is subjective evidence of response to ongoing analgesic therapy, however, no significant objective functional improvement to support continuation of this medication. Medical necessity of the requested medication has not been established. Of note, discontinuation of MS Contin should include a taper, to avoid withdrawal symptoms. The requested medication is not medically necessary.

**Lorzone 750mg qty: 60 refills: 0:** 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 Muscle Relaxants Page(s): 63.

**Decision rationale:** According to the reviewed literature, Chlorzoxazone (Lorzone) is a skeletal muscle relaxant and a central nervous system (CNS) depressant. It is closely related to the tricyclic antidepressants. According to CA MTUS Guidelines, muscle relaxants are not considered any more effective than non-steroidal anti-inflammatory medications alone. Lorzone is not recommended for the long-term treatment of chronic pain. This medication has its greatest effect in the first four days of treatment. Guidelines state that this medication is not recommended to be used for longer than 2-3 weeks. Based on the currently available information, the medical necessity for this muscle relaxant medication has not been established. The requested treatment is not medically necessary.

**Ambien 10mg qty 30 refills 0:** 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. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Insomnia treatment.

**Decision rationale:** Ambien (Zolpidem) is a prescription short-acting non-benzodiazepine hypnotic, which is approved for the short-term (usually two to six weeks) treatment of insomnia and is rarely recommended for long-term use. It can be habit-forming, and may impair function and memory more than opioid analgesics, and may increase pain and depression over the long-term. The treatment of insomnia should be based on the etiology and pharmacological agents should only be used after careful evaluation of potential causes of sleep disturbance. In this case,

there is no documentation of indications for this medication or benefits associated with its use. Also, there is no documentation of other medications tried for insomnia and outcomes. There is no documentation provided indicating the medical necessity for Ambien. The requested medication is not medically necessary.

**Xanax 0.25mg QTY 60 REFILLS 0:** 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 Benzodiazepines Page(s): 24. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Benzodiazepines.

**Decision rationale:** Alprazolam (Xanax) is a short-acting benzodiazepine drug having anxiolytic, sedative, and hypnotic properties. The medication is used in conjunction with antidepressants for the treatment of depression with anxiety, and panic attacks. Per California MTUS Guidelines, benzodiazepines are not recommended for long-term use for the treatment of chronic pain because long-term efficacy is unproven and there is a risk of dependency. Most guidelines limit use to four weeks. Medical necessity of the requested medication has not been established. The requested medication is not medically necessary.

**Zanaflex 4mg qty 60 refills 0:** 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 Muscle Relaxants Page(s): 63, 66.

**Decision rationale:** Zanaflex (Tizanidine) is a centrally acting alpha<sub>2</sub>-adrenergic agonist that is FDA approved for management of spasticity; unlabeled use for low back pain. It is indicated for the treatment of chronic myofascial pain and considered an adjunct treatment for fibromyalgia. According to CA MTUS Guidelines, muscle relaxants have not been considered any more effective than non-steroidal anti-inflammatory drugs (NSAIDs) for pain or overall improvement. There is no additional benefit shown in combination with NSAIDs. In addition, sedation is the most commonly reported adverse effect of muscle relaxant medications. The guideline criteria do not support the long-term use of muscle relaxants. Medical necessity for the requested medication has not been established. Zanaflex is not medically necessary.

**Percocet 10/325mg qty 30 refills 0:** 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 for the treatment of chronic pain Page(s): 91-97. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Opioids.

**Decision rationale:** According to the CA MTUS and the ODG, Percocet (Oxycodone /Acetaminophen) is a short-acting opioid analgesic indicated for moderate to severe pain, and is used to manage both acute and chronic pain. The treatment of chronic pain with any opioid analgesic requires review and documentation of pain relief, functional status, appropriate medication use, and side effects. A pain assessment should include current pain, intensity of pain after taking the opiate, and the duration of pain relief. In this case, there is no documentation of the medication's pain relief effectiveness, functional status, or response to ongoing opioid analgesic therapy. Medical necessity of the requested medication has not been established. Of note, discontinuation of an opioid analgesic should include a taper, to avoid withdrawal symptoms. The requested treatment with Percocet 10/325 mg is not medically necessary.

**Linze 145.ugm qty 30 refills 0:** 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) Opioids.

**Decision rationale:** Opioid-induced constipation is a common adverse effect of long-term opioid use because of the binding of opioids to peripheral opioid receptors in the gastrointestinal tract, resulting in absorption of electrolytes and reduction in small intestine fluid. According to ODG, if opioids are determined to be appropriate for the treatment of pain then prophylactic treatment of constipation should be initiated. According to the ODG, Linze is recommended for the treatment of constipation only if first-line treatments for opioid-induced constipation have failed. In this case, the opioids were not found to be medically necessary. Medical necessity for the requested medication has not been established. The requested medication is not medically necessary.