MAXIMUS Federal Services

Case Number:	CM15-0012158		
Date Assigned:	01/29/2015	Date of Injury:	11/27/1996
Decision Date:	03/18/2015	UR Denial Date:	01/15/2015
Priority:	Standard	Application Received:	01/21/2015

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: Pennsylvania
Certification(s)/Specialty: Family Practice

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 63 year old male, who sustained an industrial injury on 11/27/1996. Details of the initial injury were not included for this review. The diagnoses have included chronic low back pain, failed back surgery, lumbar radiculopathy, bilateral shoulder impingement syndrome, anxiety and depression. Treatment to date documented has included Non-Steroidal Anti-Inflammatory Drugs (NSAIDs), analgesics, muscle relaxer, and anti-depressant, heat/cold, rest, and home exercise. Currently, the IW complains of pain in bilateral legs, shoulders, buttocks and knees, and bilateral low back rated 6-8/10 VAS that improves with rest, heat, medication, walking, ice, and changing positions. Physical examination from 1/7/15 documented observance of grimaces and slow transition described performed as "gingerly", slow antalgic gate with single point cane. The plan of care included continuation of medication, home exercises and aqua therapy. On 1/15/2015 Utilization Review modified certification for Terazosin Hydrochloride 5mg #30 and Effexor ER 75mg #45, Zanaflex 6mg #30, and Zonegran 100mg #60, noting the documentation did not include efficacy of the requested treatments. The MTUS Guidelines were cited. On 1/21/2015, the injured worker submitted an application for IMR for review of Terazosin Hydrochloride 5mg #60 and Effexor ER 75mg #90, Zanaflex 6mg #60, and Zonegran 100mg #120.

IMR ISSUES, DECISIONS AND RATIONALES

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

60 Capsules of Terazosin Hydrochloride 5mg: 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), Diabetes, Hypertension treatment

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines CRPS, medications Page(s): 38.

Decision rationale: According to the MTUS, alpha 1 adrenoceptor blocking agents such as terazosin have been shown to be effective in a case report for sympathetically maintained pain. The medical record does not state what this medication is being used for in this case. Sympathetically maintained pain is not included in the diagnoses. It may be being used for benign prostatic hypertrophy but there is no diagnosis of this although there is subjective complaint of frequent urination at night and difficulty starting urination. This medication is also used for hypertension but the record does not indicate that it is being used for that purpose. In summary, the record does not indicate the purpose or discuss any benefit the worker is receiving from this medication and therefore does not appear to be medically necessary.

90 tablets of Effexor Extended Release 75mg: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines SSRIs Page(s): 15-16.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressants, Venlafaxine Page(s): 13-15 and 123.

Decision rationale: Effexor is a selectie serotonin and norepinephrine reuptake inhibitor (SNRI) antidepressant. It is recommended as an option in first-line treatment of neuropathic pain and in depression. In non-neuropathic pain it is recommended as an option in depressed patient's but effectiveness is limited. SNRI's have not been evaluated for low back pain. Antidepressants are an option for radiculopathy but there are no specific medications that have been proven in high quality studies to be efficasious for treatment of lumbosacral radiculopathy. This worker has a diagnosis of depression but the record does not include any documentation of benefit or response to Effexor so it cannot be determined to be medically necessary.

60 Capsules of Zanaflex 6mg: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antispesticity/Antispasmodic Drugs Page(s): 64-66.

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

Decision rationale: Zanaflex is a muscle relaxant. Non-sedating muscle relaxants are recommended with caution as a second-line option for short-term treatment of acute exacerbations in patients with chronic LBP. In most LBP cases, they show no benefit beyond NSAIDs in pain and overall improvement and there is no additional benefit shown in combination with NSAIDs. Zanaflex is a centrally acting alpha2-adrenergic agonist that is FDA approved for management of spasticity and is used off label for low back pain. In this case, the long term use of a muscle relaxant is not appropriate. It appears that this worker has been using Zanaflex for at least several months. There is no indication that the medication is being used for an acute exacerbation of low back pain nor is any other rationale provided for the long term use of this medication.

120 Capsules of Zonegran 100mg: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Other Antiepileptic Drugs Page(s): 21-22.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antiepilepsy Drugs Page(s): 16-22.

Decision rationale: Zonegran is an antiepilepsy drug. Antiepilepsy drugs (AEDs) are recommended for neuropathic pain. Most randomized controlled trials for the use of AEDs for neuropathic pain have been directed at postherpetic neuralgia and painful polyneuropathy. None have been directed at painful radiculopathy. According to the MTUS, Zonegran may be effective for neuropathic pain but the ultimate role of this agent requires further research and experience. In the interim, it should only be used to treat neuropathic pain when carbamezepine, gabapentin, or lamotrigine cannot be used. There is no indication in the medical record that one of these other agents cannot be used. Furthermore, there is no clear indication for the use of AEDs in this case.