

<b>Case Number:</b>	CM15-0113275		
<b>Date Assigned:</b>	06/19/2015	<b>Date of Injury:</b>	06/19/2009
<b>Decision Date:</b>	07/27/2015	<b>UR Denial Date:</b>	05/16/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/11/2015

### 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 66-year-old male who sustained a work related injury June 19, 2009. While moving a large steel plate, weighing over 100 pound, he turned to set it down and felt a popping sensation, along with pain in the lower back, radiating into the right lower extremity. He was initially treated with medication, physical therapy, and underwent x-rays. Past history included hypertension. According to a primary treating physician's progress report, dated May 7, 2015, the injured worker presented with chronic and debilitating low back pain. The previous night her reports a panic attack, he was out of Ativan and unable to sleep. He rates his pain as 7.10 with medication and 10/10 without medication. Examination of the lumbar spine revealed straight leg raise positive bilaterally at 60 degrees, positive paraspinal muscle spasm and motor weakness 4/5 bilaterally with decreased range of motion. Diagnoses are lumbar discogenic disease multilevel, L2-S1 with stenosis L2-S1; chronic lumbar spine sprain/strain; chronic low back pain; lumbar facet arthropathy; annular tear L3-4, L4-5, L5-S1. Treatment plan included continue with medication, psychological and vascular consult for surgical clearance and at issue, request for authorization for Norco, Zanaflex, Ativan, Toradol injection, and massage therapy.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Norco 10/325 mg Qty 180: Upheld**

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

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

**Decision rationale:** According to MTUS and ODG, Norco 10/325mg (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 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 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.

**Zanaflex 4 mg Qty 90:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Tizanidine (Zanaflex); Muscle relaxants.

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

**Decision rationale:** Zanaflex (Tizanidine) is a centrally acting alpha2-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. In this case, the patient has reported lumbar spasm on physical exam but the guideline criteria do not support the long-term use of muscle relaxants. In addition, there is no documentation of a maintained increase in function or decrease in pain with this medication. Medical necessity for the requested medication has not been established. The requested Zanaflex is not medically necessary.

**Ativan 1 mg Qty 90:** Upheld

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

**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:** According to the CA MTUS guidelines, benzodiazepines are prescribed for anxiety. They 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. Ativan (Lorazepam) is a long-acting benzodiazepine, having anxiolytic, sedative, muscle relaxant, anticonvulsant, and hypnotic properties. Most guidelines recommend the use of Ativan for the treatment of anxiety disorders, and as an adjunct treatment for anxiety associated with major depression. Use of this medication is limited to four weeks. There are no guideline criteria that support the long-term use of benzodiazepines. Medical necessity for the requested medication has not been established. The requested medication is not medically necessary.

**1 Toradol 60 mg IM (intramuscular) injection:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Ketorolac (Toradol). Decision based on Non-MTUS Citation Official Disability Guidelines: Pain (acute & chronic) - Ketorolac (Toradol).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): 21, 67-71. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) NSAIDs.

**Decision rationale:** Ketorolac (Toradol) is a non-steroidal anti-inflammatory drug (NSAID). The oral form is only recommended for short-term (up to 5 days) management of moderately severe acute pain that requires analgesia at the opioid level, and only as a continuation following IV or IM dosing, if necessary. This medication is not indicated for minor or chronic painful conditions. The single IM dose is 60mg or 30mg every 6 hours, not to exceed 120 mg/day. The oral dose is 20mg once after IV or IM therapy, then 10mg every 4-6 hours, not to exceed 40 mg/day. The guidelines do not recommend Toradol for chronic pain, as in this case. Medical necessity for an IM Toradol injection has not been established. The requested medication is not medically necessary.

**Massage therapy, 6 visits:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Massage/myotherapy.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Massage Therapy.

**Decision rationale:** Massage therapy is recommended as an option in conjunction with recommended exercise programs. Manual massage administered by professional providers has shown some proven efficacy in the treatment of acute low back symptoms, based on quality studies. Mechanical massage devices are not recommended. Massage therapy should be limited

to 4-6 visits in most cases. It is beneficial in attenuating diffuse musculoskeletal symptoms, but beneficial effects were registered only during treatment. A recent meta-analysis concluded that massage might be beneficial for patients with sub acute and chronic non-specific low-back pain, especially when combined with exercises and education. When massage was compared to other active treatments, massage was similar to exercises, and massage was superior to joint mobilization, relaxation therapy, physical therapy, and acupuncture and self-care education. The beneficial effects of massage in patients with chronic low-back pain lasted at least one year after the end of the treatment. In comparing different techniques of massage, acupuncture massage produced better results than classic (Swedish) massage and Thai massage produced similar results to classic (Swedish) massage. The ODG recommends frequency and duration of treatment for massage therapy are the same as Manipulation: A trial of 6 visits over 2 weeks, with evidence of objective functional improvement, total of up to 18 visits over 6-8 weeks. In this case, there is no documentation of a program of exercise or functional restoration to indicate that massage therapy is medically necessary at this time. The requested massage therapy is not medically necessary.