

<b>Case Number:</b>	CM15-0117579		
<b>Date Assigned:</b>	06/25/2015	<b>Date of Injury:</b>	04/20/1997
<b>Decision Date:</b>	09/11/2015	<b>UR Denial Date:</b>	06/11/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/18/2015

### 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: California

Certification(s)/Specialty: Emergency 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:

The injured worker is a 54 year old male who sustained an industrial injury on 04/20/1997. Mechanism of injury was not documented. Diagnoses include lumbago, displacement of lumbar disc without myelopathy, degeneration of lumbo/lumbosacral intervertebral disc. Treatment to date has included diagnostic studies, and medications. He is status post laminotomy in 2000, status post radiofrequency neurotomy on the right L3-4, L4-5, and L5-S1 on 05/20/2010, and status post lumbar fusion with instrumentation done in December of 2012. A physician progress note dated 05/21/2015 documents the injured worker complains of spasms up and down his back. He has continued pain in his mid-back down to his sacral region. He states that recently had an episode of bowel incontinence. He also had electric shock pain radiating down his left to his left heel. He also has some pain radiating down the right leg to his heel. He rates his pain as 10 out of 10 without his medications and with his medications, his pain is 7 out of 10 at its best. He ambulates with a stiff antalgic gait. He has functional range of motion and 5/5 strength of his lower extremities with increase sensation to the right and left with light touch. He has limited range of motion of the back in all directions. He bends knees to touch the floor. He has tenderness to palpation in the spinous process of the lumbar region of the back. There is documentation that the injured worker has been on Ambien, Paxil, Vicodin, Voltaren Gel, Xanax and Zanaflex since at least 06/03/2014. Treatment requested is for Ambien 10mg #30, Horizant 600mg #60, Paxil 20mg #30, Vicodin 5/325 #60, Voltaren Gel 1%, 100gm #5 tubes, Xanax 0.25mg #60, and Zanaflex 4mg #90.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Paxil 20mg #30:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines  
Page(s): 14 of 127.

**Decision rationale:** The request is for the use of a medication in the class of a selective serotonin reuptake inhibitor. The MTUS guidelines state the following regarding this topic: Low Back Pain: Chronic: A systematic review indicated that tricyclic antidepressants have demonstrated a small to moderate effect on chronic low back pain (short-term pain relief), but the effect on function is unclear. This effect appeared to be based on inhibition of norepinephrine reuptake. SSRIs have not been shown to be effective for low back pain (there was not a significant difference between SSRIs and placebo) and SNRIs have not been evaluated for this condition. (Chou, 2007) Reviews that have studied the treatment of low back pain with tricyclic antidepressants found them to be slightly more effective than placebo for the relief of pain. A non-statistically significant improvement was also noted in improvement of functioning. SSRIs do not appear to be beneficial. (Perrot, 2006) Radiculopathy: Antidepressants are an option, but there are no specific medications that have been proven in high quality studies to be efficacious for treatment of lumbosacral radiculopathy. (Dworkin, 2007) In this case, the use of this medication is not indicated per the guidelines. Reviews have found the use of SSRIs ineffective for low back pain. There are no specific antidepressant medications that have been proven to be efficacious for lumbosacral radiculopathy. As such, the request is not medically necessary.

**Horizant 600mg #60:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines  
Page(s): 16-17 of 127.

**Decision rationale:** The request is for the use of a medication in the category of an anti-epileptic drug (AED). These medications are recommended for certain types of neuropathic pain. Most of the randomized clinical control trials involved include post-herpetic neuralgia and painful polyneuropathy such as in diabetes. There are few trials that have studied central pain or radiculopathy. The MTUS guidelines state that a good response to treatment is 50% reduction in pain. At least a 30% reduction in pain is required for ongoing use, and if this is not seen, this should trigger a change in therapy. There should also be documentation of functional improvement and side effects incurred with use. Disease states which prompt use of these medications include post-herpetic neuralgia, spinal cord injury, chronic regional pain syndrome, lumbar spinal stenosis, post-operative pain, and central pain. There is inadequate evidence to

support use in non-specific axial low back pain or myofascial pain. In this case, there is inadequate documentation of a condition, which would support the use of an anti-epileptic drug. The records also do not reveal functional improvement or screening measures as required. As such, the request is not medically necessary.

**Voltaren Gel 1% 100 gm #5 tubes:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111-113 of 127.

**Decision rationale:** The request is for the use of Voltaren gel for topical use to aid in pain relief. This medication would be classified as an NSAID and aids in inflammation reduction. Qualifying factors for this product is indicated by the following per the guidelines: The efficacy in clinical trials for this treatment modality has been inconsistent and most studies are small and of short duration. Topical NSAIDs have been shown in meta-analysis to be superior to placebo during the first 2 weeks of treatment for osteoarthritis, but either not afterward, or with a diminishing effect over another 2-week period. (Lin, 2004) (Bjordal, 2007) (Mason, 2004) When investigated specifically for osteoarthritis of the knee, topical NSAIDs have been shown to be superior to placebo for 4 to 12 weeks. Indications: Osteoarthritis and tendinitis, in particular, that of the knee and elbow or other joints that are amenable to topical treatment: Recommended for short-term use (4-12 weeks). There is little evidence to utilize topical NSAIDs for treatment of osteoarthritis of the spine, hip or shoulder. FDA-approved agents: Voltaren Gel 1% (diclofenac): Indicated for relief of osteoarthritis pain in joints that lends themselves to topical treatment (ankle, elbow, foot, hand, knee, and wrist). It has not been evaluated for treatment of the spine, hip or shoulder. In this case, as stated above, the patient would not qualify for the use of a topical NSAID. This is based on the diagnosis and treatment duration. As such, the request is not medically necessary.

**Xanax 0.25 mg #60:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepine. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Benzodiazepine.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 24 of 127.

**Decision rationale:** The request is for the use of a medication in the category of benzodiazepines. It is usually indicated to treat anxiety disorders but has been used short-term as a muscle relaxant. The MTUS guidelines state the following: 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 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 anticonvulsant and muscle relaxant effects occurs within weeks. (Baillargeon, 2003) (Ashton, 2005) In this case, a medication in this class would not be advised for continued use due to the duration of therapy. As such, the request is not medically necessary.

**Ambien 10mg #30:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 15 Stress Related Conditions Page(s): 399.

**Decision rationale:** The request is for the use of a sleep aid. The need for this type of medication is varied and includes side effects of pharmaceuticals taken, stress, or even psychiatric conditions. Prior to use, a proper work-up is required delineating the etiology of the sleep disturbance. This may require a psychiatric evaluation. Further, restorative measures should initially include improving sleep hygiene, reducing caffeine intake and fat rich foods. In this case, the required evaluation and initial treatment measures are not seen. As such, the request is not medically necessary.

**Zanaflex 4 mg #90:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 63 of 127.

**Decision rationale:** The request is for the use of a muscle relaxant to aid in pain relief. The MTUS guidelines state that the use of a medication in this class is indicated as a second-line option for short-term treatment of acute exacerbations of low back pain. Muscle relaxants may be effective in reducing pain and muscle tension, which can increase mobility. However, in most LBP cases, they show no benefit beyond NSAIDs in pain improvement. Efficacy appears to diminish over time, and prolonged use may lead to dependence. (Homik, 2004) Due to inadequate qualifying evidence for use of a muscle relaxant, the request is not medically necessary.

**Vicodin 5/300mg #60:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 78 of 127.

**Decision rationale:** The request is for the use of a medication in the opioid class. The MTUS guidelines state that for ongoing treatment with a pharmaceutical in this class, certain requirements are necessary. This includes not only adequate pain control, but also functional improvement. Four domains have been proposed for management of patients on opioids. This includes pain relief, side effects, physical and psychosocial functioning, and the occurrence of any potentially aberrant drug-related behaviors. In this case, there is inadequate documentation of persistent functional improvement, which should eventually lead to medication discontinuation. The records also do not reveal screening measures as discussed above for continued use of a medication in the opioid class. As such, the request is not medically necessary.