

Case Number:	CM15-0172089		
Date Assigned:	09/14/2015	Date of Injury:	09/07/2001
Decision Date:	11/06/2015	UR Denial Date:	08/20/2015
Priority:	Standard	Application Received:	09/01/2015

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 58 year old male who sustained an industrial injury on 9-7-01. Diagnoses include traumatic brain injury, status post concussive syndrome, status post-traumatic stress disorder; cervical spine disc syndrome with sprain, strain disorder, radiculopathy, status post laminectomy fusion, post-operative laminectomy fusion syndrome; lumbosacral spine disc syndrome with sprain, strain disorder, radiculopathy, status post laminectomy fusion, post-operative laminectomy fusion syndrome; chronic pain syndrome. He currently (8-3-15) complains of sharp, stabbing pain, weakness, numbness, paresthesia and generalized discomfort of the neck and low back. Pain ratings were not enumerated. On 8-11-14 he complained of sharp, stabbing pain, weakness, numbness, paresthesia and generalized discomfort of the neck and low back. On physical exam there was decreased range of motion of the cervical and lumbosacral spines in all planes; absent right biceps and right ankle deep tendon reflexes; reduced sensation and strength in the distribution of the right C6 and right S1 spinal nerve roots; reduced bilateral straight leg raise measurements; tender, painful right cervical and right lumbosacral paraspinal muscular spasms. Treatments to date include medications: (current) Duragsic patches, Norco, Mobic, Zanaflex, Soma, Ambien. Drug screens dated 1-12-15, 3-9-15 and 5-11-15 were inconsistent with prescribed medications. In the progress note dated 8-3-15 the treating provider's plan of care includes requests for Norco 10-325mg as needed #90 with no refills; Zanaflex 4mg #60 with 5 refills to reduce painful myositis; Ambien 12.5mg as needed to reduce insomnia; meloxicam 15mg #30 to reduce inflammation. The injured worker has been on Ambien per the 8-11-14 progress note; Norco per 9-8-14 progress note; Mobic and Zanaflex per

the 5-11-15 progress note. The request for authorization dated 8-3-15 requests meloxicam 15mg #30; Zanaflex 4mg #60. On 8-20-15 utilization review modified or non-certified the requests for Norco 10-325mg as needed #90 with no refills, modified based on no objective improvement; Zanaflex 4mg #60 with 5 refills to reduce painful myositis without subjective or objective improvement documented; Ambien 12.5mg as needed to reduce insomnia based on prior use for weaning purposes; meloxicam 15mg #30 to reduce inflammation, modified based on additional prescription for this medication is not warranted based on no documentation of subjective or objective improvement.

IMR ISSUES, DECISIONS AND RATIONALES

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

Norco 10/325mg #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids for chronic pain. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Opioids.

Decision rationale: According to the CA 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 insufficient evidence that the opioids were prescribed according to the CA MTUS guidelines, which recommend prescribing according to function, with specific functional goals, return to work, random drug testing, an opioid contract, and documentation of a prior failure of non-opioid therapy. There is no documentation of significant pain relief or increased function from the opioids used to date. 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 medication is not medically necessary.

Meloxicam 15mg #30: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): NSAIDs (non-steroidal anti-inflammatory drugs).

Decision rationale: Mobic (Meloxicam), is a non-steroidal anti-inflammatory drug (NSAID). Oral NSAIDs are recommended for the treatment of chronic pain and control of inflammation as a second-line therapy after acetaminophen. The ODG states that NSAIDs are recommended for

acute pain, acute low back pain (LBP), short-term pain relief in chronic LBP, and short-term improvement of function in chronic LBP. There is no evidence of long-term effectiveness for pain or function. Guidelines recommended that the lowest effective dose be used for the shortest duration of time consistent with treatment goals. In this case, the patient has a chronic pain syndrome and the medication has been proven to be beneficial. Medical necessity for the requested medication has been established. The requested medication is medically necessary.

Zanaflex 4mg #60 with 5 refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Muscle relaxants (for pain).

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. Per the CA MTUS guidelines, Zanaflex is a muscle relaxant used as a second-line option for the short-term treatment of acute exacerbations in patients with chronic LBP. According to the 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, there is no documentation of a maintained increase in function or decrease in pain with the use of this medication. Medical necessity for the requested medication has not been established. The requested medication is not medically necessary.

Ambien 12.5mg #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 (ODG), Mental Illness and Stress, Zolpidem (Ambien).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. 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 recommended for short-term treatment of insomnia (two to six weeks). Ambien is indicated for treatment of insomnia with difficulty of sleep onset and/or sleep maintenance. Longer-term studies have found Ambien to be effective for up to 24 weeks in adults. It can be habit-forming, and may impair function and memory more than opioid analgesics. There is also concern that Ambien 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, Ambien has been used for greater than 6 months. There is no documentation provided indicating medical necessity for the long-term use of Ambien. The requested medication is not medically necessary.