

Case Number:	CM15-0177725		
Date Assigned:	09/18/2015	Date of Injury:	12/31/2006
Decision Date:	11/12/2015	UR Denial Date:	09/09/2015
Priority:	Standard	Application Received:	09/09/2015

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: Internal 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 40 year old female who sustained an industrial injury on 12-31-06. Diagnoses included chronic pain syndrome; postlaminectomy syndrome, lumbar; lower back pain; lumbar-thoracic radiculopathy; muscle spasms. She currently (8-25-15) complains of constant low back pain with a pain level of 9 out of 10 with medication and 10 out of 10 without medication. On physical exam of the lumbar spine there was restricted range of motion, tenderness of the paraspinal and lumbar facets at L4-S1, positive straight leg raise on the right; right foot swelling and decreased range of motion. The 7-28-15 note indicated muscle spasms in the legs and low back. Per the 8-25-15 progress note, the current medication regimen has stabilized her pain and she can perform activities of daily living. There has not been a pain medication reduction because of continuous pain. Her pain level has remained unchanged at 9 out of 10 with medication and 10 out of 10 without medications from 3-11-15 through 8-25-15 documentation. Treatments to date include medications: oxycodone, Opana, gabapentin, Ketoprofen, Zanaflex, Lidoderm patches 5% (on 8-25-15, a drug screen was done); physical therapy without benefit; transcutaneous electrical nerve stimulator unit with benefit. The request for authorization dated 8-31-15 indicated oxycodone 30mg #90; Opana ER 20mg #120; gabapentin 400mg #180 ; Zanaflex 2mg #90; Voltaren XR 100mg #60; Lidoderm patch 5% #30. On 9-9-15, utilization review evaluated and modified: oxycodone 30mg #90 modified to oxycodone 30mg #60 and Opana ER 20mg #120 to Opana ER 20mg #90 based on no documentation of functional improvement on these medications, no documentation of proper monitoring, gabapentin 400mg #180 to gabapentin 400mg #120 based on no documentation of

objective findings of radiculopathy or that she has neuropathy, Zanaflex 2mg #90 to Zanaflex 2mg #60 based on no documentation of muscle spasms, no documentation of extenuating circumstances to support long term use; non-certified Voltaren XR 100mg #60 based on no documentation of functional improvement or extenuating circumstances to support long term use; Lidoderm patch 5% #30 based on no documentation of failure of first line treatment or that she cannot tolerate oral medication.

IMR ISSUES, DECISIONS AND RATIONALES

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

Oxycodone 30mg #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) Pain Chapter--Opioids.

Decision rationale: According to the CA MTUS and ODG, Oxycodone is an 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 and any functional improvement from previous usage. 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 Oxycodone 30mg #90 is not medically necessary.

Opana ER 20mg #120: 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) Pain Chapter--Opioids.

Decision rationale: According to the CA MTUS and ODG, Opana ER is an opioid agonist indicated for severe 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. There is no compelling evidence presented by the treating provider that indicates this injured worker, had any significant improvements from use of this medication, and also review of Medical Records do not indicate that previous use of this

medication has been effective in maintaining any measurable objective evidence of 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 Opana ER 20mg #120 is not medically necessary and appropriate.

Gabapentin 400mg #180: 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): Antiepilepsy drugs (AEDs). Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter-- Anti-epilepsy drugs (AEDs) for pain.

Decision rationale: According to the CA MTUS (2009) and ODG, Neurontin (Gabapentin) is an anti-epilepsy drug, which has been shown to be effective for treatment of diabetic painful neuropathy and post-herpetic neuralgia, and has been considered as a first-line treatment for neuropathic pain. Neurontin has been part of her medical regimen. However In this case, there is no compelling evidence presented by the treating provider that indicates this injured worker has had any significant improvements from this medication, and also review of Medical Records do not clarify that previous use of this medication has been effective in this injured worker for maintaining the functional improvement. Medical necessity for Neurontin has not been established. The request is not medically necessary.

Voltaren XR 100mg #60: 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): NSAIDs (non-steroidal anti-inflammatory drugs).

Decision rationale: Voltaren (Diclofenac Sodium) is classified as a non-steroidal anti-inflammatory drug (NSAID). According to California MTUS Chronic Pain Medical Treatment Guidelines, NSAIDs are "recommended for osteoarthritis at the lowest dose for the shortest period in patients with moderate to severe pain. Acetaminophen may be considered for initial therapy for patients with mild to moderate pain, and in particular, for those with gastrointestinal, cardiovascular, or renovascular risk factors." Under back pain - chronic low back pain, it is "recommended as an option for short term symptomatic relief" and "that non-steroidal anti-inflammatory drugs (NSAIDs) were no more effective than other drugs such as acetaminophen, narcotic analgesics, and muscle relaxants." Review of the received medical records do not indicate that Voltaren (Diclofenac Sodium) is providing any specific analgesic benefits, such as percent pain reduction or reduction in pain level, or any objective functional improvement. In addition, there is no documentation of why the injured worker is being prescribed Voltaren. Therefore, based on the Guidelines and submitted medical records, the request for Voltaren XR 100mg #60 is not medically necessary.

Zanaflex 2mg #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): Muscle relaxants (for pain). Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter --Muscle relaxants.

Decision rationale: According to the reviewed literature, Zanaflex is not recommended for the long-term treatment of chronic pain. This medication has its greatest effect in the first four days of treatment. In addition, this medication is not recommended to be used for longer than 2-3 weeks. According to CA MTUS Guidelines, muscle relaxants are not considered any more effective than non-steroidal anti-inflammatory medications alone. In this case, the available records are not clear if the injured worker has shown a documented benefit or any functional improvement from prior Zanaflex use. Based on the currently available information, the medical necessity for this muscle relaxant medication has not been established. The requested treatment Zanaflex 2mg #90 is not medically necessary.

Lidoderm patch 5% #30: 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): Topical Analgesics. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter--Lidoderm® (lidocaine patch).

Decision rationale: Lidoderm is the brand name for a lidocaine patch. Topical lidocaine may be recommended for localized peripheral pain after there has been evidence of a trial of first-line therapy (tricyclic or SNRI anti-depressants, or an AED, such as gabapentin or Lyrica). Lidoderm patches are not a first-line treatment and are only FDA approved for post-herpetic neuralgia. Further research is needed to recommend this treatment for chronic neuropathic pain disorders other than post-herpetic neuralgia. In addition, this medication is not generally recommended for treatment of osteoarthritis or treatment of myofascial pain/trigger points. In this case, medical necessity of the requested item has not been established. Medical necessity of the requested 5% Lidoderm patches has not been established. The requested Lidoderm patches are not medically necessary. Submitted Records do not document neuropathic pain in this injured worker and there is no documentation that the injured worker has failed a trial of antidepressants and anticonvulsants and is intolerant to other medicines. Based on the currently available information in the submitted Medical Records of this injured worker, and per review of guidelines, the medical necessity of the requested treatment: Lidoderm 5%, is not medically necessary and appropriate.