MAXIMUS Federal Services

Case Number:	CM15-0178269		
Date Assigned:	09/28/2015	Date of Injury:	11/07/2001
Decision Date:	12/04/2015	UR Denial Date:	09/03/2015
Priority:	Standard	Application Received:	09/10/2015

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: Pediatrics, 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 a 59 year old female, who sustained an industrial injury on November 7, 2001. The initial symptoms reported by the injured worker are unknown. The injured worker was currently diagnosed as having myospasms, status post removal of cervical hardware with intraoperative documentation of osseous fusion from April 18, 2007, multiple-level degenerative disc disease lumbar spine, moderate to severe disc height loss L3-4 with a posterior disc bulge, moderate disc height loss L4-5 with spondylosis and type II motic changes, rule out neurogenic bladder, status post lumbar spine surgery from December 2012 and status post permanent implant spinal cord stimulator in 2015. Treatment to date has included diagnostic studies, trigger point injections with immediate pain relief, surgery and medication. On August 13, 2015, the injured worker complained of ongoing difficulty with pain in her neck, shoulders and bilateral upper extremities. Her pain was described as burning, aching, throbbing, tingling, tightness, spasms, numbness, tenderness, swelling, weakness and pressure. She denied any significant changes in her condition since her last office visit. The pain was rated as a 9 on a 1-10 pain scale in intensity, but as a 7 on the pain scale with medications. She stated that she begins to feel relief within 30-45 minutes of taking medication with relief lasting for approximately 48 hours, depending upon the medication. Without medication, she stated that she is limited to 5 minutes of walking, 15 minutes of sitting, 8 minutes of standing and 3 hours of sleeping. She is unable to tolerate lifting over 5 pounds, brushing her hair, getting dressed without multiple breaks and showering. With medication, she is able to walk for 5 minutes, sit for 30 minutes and stand for 20 minutes. Physical examination revealed tenderness to palpation over the paraspinal muscles

in the lumbar and thoracic region bilaterally. Range of motion of the lumbar spine was significantly limited secondary to pain. The treatment plan included MS Contin, Flexeril, Famotidine, Lorazepam, Ambien, Percocet, Pramipexole, Tramadol HCL, Methocarbamol, Lidoderm patch, Amitiza and Orphenadrine ER. A request was made for MS Contin CR, Flexeril, Lorazepam, Ambien, Percocet, Pramipexole, Tramadol HCL, Methocarbamol, Lidoderm patch and Orphenadrine ER.

IMR ISSUES, DECISIONS AND RATIONALES

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

MS Contin CR 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, criteria for use.

Decision rationale: The IW has been on long term opioids which are not recommended. Additionally, documentation did not include review and documentation of pain relief, functional status, appropriate medication use, and side effects. Pain assessment should include: current pain; the least reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid; how long it takes for pain relief; and how long pain relief lasts. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. This request is not medically necessary and reasonable.

Flexeril 10mg #90, 3 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: Flexeril is recommended as an option for muscle spasms using a short course of therapy. Treatment should be brief, no longer than 2-3 weeks. There is no clear evidence in the notes provided that the IW has benefit from the muscle relaxer and at this time frame routine use of these medications is not indicated, therefore is not medically necessary.

Lorazepam 1mg #60, 3 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): Benzodiazepines.

Decision rationale: Benzodiazepines, like lorazepam, are 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 sedative/hypnotic, anxiolytic, anticonvulsant, and muscle relaxant. Chronic 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. This request is not medically necessary and appropriate.

Ambien 10mg #30, 3 refills: 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, Zolpidem.

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: Per ODG pharmacological agents for insomnia should only be used after careful evaluation of potential causes of sleep disturbance for the etiology. Ambien is indicated for the short-term treatment of insomnia with difficulty of sleep onset (7-10 days). There is no discussion of an investigation into the origin of the sleep disturbance and non-pharmacological interventions that may have been utilized. This request is not medically necessary.

Percocet 10/325mg #180 (plus 1 postdated note): 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, criteria for use.

Decision rationale: The IW has been on long term opioids which are not recommended. Additionally, documentation did not include review and documentation of pain relief, functional status, appropriate medication use, and side effects. Pain assessment should include: current pain; the least reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid; how long it takes for pain relief; and how long pain relief lasts. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. This request is not medically necessary and reasonable.

Pramipexole 0.125mg #90, 3 refills: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Drugs.com Issued: 3 June 2015 Accessed 3 September 2015.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee & Leg - Restless Leg Syndrome.

Decision rationale: Per ODG guidelines, restless leg syndrome is recommended to be diagnosed and treated as indicated below. Diagnostic Criteria: There are four essential criteria. (1) An urge to move the legs, usually accompanied by uncomfortable and unpleasant sensations in the legs. Pain is often a primary component (reported as often as 50% of the time). Symptoms may involve the arms or other body parts. (2) The urge to move/unpleasant sensations become worse during periods of rest or inactivity. (3) Movement partially relieves the urge to move/unpleasant sensations (at least as long as the movement continues). & (4) The urge to move/unpleasant sensations are generally worse at night, or only occur at night. Supportive Clinical Features: (1) Positive family history (more than 50% of patients); (2) Response to dopaminergic therapy; & (3) Periodic limb movements are reported in sleep (rhythmic extension of the big toe and dorsiflexion of the ankle, with occasional flexion of the knee and hip). These movements can also occur in individuals with narcolepsy, sleep apnea, other medical conditions, and in patients treated with various medications. There is no documentation of diagnostic features or of response to medication in the past. The request is not medically necessary and appropriate.

Tramadol HCL 50mg #120, 3 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): Opioids, criteria for use.

Decision rationale: The IW has been on long term opioids which are not recommended. Additionally, documentation did not include review and documentation of pain relief, functional status, appropriate medication use, and side effects. Pain assessment should include: current pain; the least reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid; how long it takes for pain relief; and how long pain relief lasts. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. This request is not medically necessary and reasonable.

Methocarbamol 750mg #120, 3 refills: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back - Muscle relaxants.

Decision rationale: According to MTUS guidelines non-sedating muscle relaxants are recommended for use with caution as a second-line option for short-term treatment of acute exacerbations in patients with chronic LBP. Per ODG guidelines, muscle relaxants are recommended as an option in acute cases of moderate to severe LBP. OK for acute spasms. Muscle relaxants are commonly used for the treatment of low back problems. The therapeutic objective of muscle relaxants is to reduce low back pain by relieving muscle spasm. However, the concept of skeletal muscle spasm is not universally accepted as a cause of symptoms, and the most commonly used muscle relaxants have no peripheral effect on muscle spasm. There are tender muscles noted on exam but no documentation of response to these medications. The request is not medically necessary and appropriate.

Lidoderm 5% patch #60, 3 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): Topical Analgesics.

Decision rationale: According to MTUS guidelines topical lidocaine is indicated for neuropathic pain. It is recommended for localized peripheral pain after there has been evidence of a trial of first-line therapy (tri-cyclic or SNRI anti-depressants or an AED such as gabapentin or Lyrica). There is no evidence that the IW had been on an SNRI nor was there any definitive evidence of neuropathy such as an EMG/NCV. This request is not medically necessary and appropriate.

Orphenadrine ER 100mg #60, 3 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: MTUS recommends non-sedating muscle relaxants with caution as a second-line option for short-term treatment of acute exacerbations in patients with chronic LBP. It is noted that in most LBP cases, they show no benefit beyond NSAIDs in pain and overall improvement. Also there is no additional benefit shown in combination with NSAIDs. Efficacy appears to diminish over time, and prolonged use of some medications in this class may lead to dependence. The IW is noted to be on numerous opioids and that the muscle relaxant is to be taken twice daily regularly. The request is not medically necessary and appropriate.