

Case Number:	CM15-0077533		
Date Assigned:	06/05/2015	Date of Injury:	07/18/2001
Decision Date:	07/08/2015	UR Denial Date:	04/07/2015
Priority:	Standard	Application Received:	04/22/2015

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 43 year old female, who sustained an industrial injury on 07/18/2001. She has reported subsequent back pain and was diagnosed with post-laminectomy syndrome of the lumbar spine, lumbar displacement, spondylosis of the lumbar spine, lumbosacral radiculopathy and chronic pain. The injured worker was also diagnosed with recurrent major depression and panic disorder with agoraphobia. Treatment to date has included oral and topical pain medication, sacroiliac injections, epidural injections, TENS unit, physical and occupational therapy, chiropractic therapy, a home exercise program and surgery. In a progress note dated 03/23/2015, the injured worker complained of low back pain and stiffness. Objective findings were notable for decreased sensation to light touch of the S1 and L5 dermatome, pain with Valsalva of the lumbosacral spine, positive FABER and Patrick's tests, pain to palpation over the L4 to L5 and L5 to S1 facet capsules bilaterally and pain with rotational extension. A request for authorization of Alprazolam, Zanaflex, Gabapentin, Fiorinal, Lidocaine and Zofran was submitted.

IMR ISSUES, DECISIONS AND RATIONALES

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

Alprazolam 2mg: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines, Muscle Relaxants. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain (Chronic), Alprazolam (Xanax), Anxiety medications in chronic pain, 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: Alprazolam (Xanax) is a short-acting benzodiazepine drug having anxiolytic, sedative, and hypnotic properties. The medication is used in conjunction with antidepressants for the treatment of depression with anxiety, and panic attacks. Per California MTUS Guidelines, benzodiazepines 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. Most guidelines limit use to four weeks. Medical necessity of the requested medication has not been established. The requested medication is not medically necessary.

Zanaflex 4mg: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain (Chronic), Tizanidine (Zanaflex).

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 the 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, there is no documentation of acute exacerbations of chronic pain/low back pain. In addition, there is no documentation of functional improvement with use of this medication. Also, the guideline criteria do not support the long-term (>2 wks) use of muscle relaxants. Medical necessity for the requested medication has not been established. The requested medication, Zanaflex, is not medically necessary.

Gabapentin 600mg #270 with 3 refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-epilepsy drugs, Neurontin (gabapentin).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Gabapentin Page(s): 17-19, 49. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Gabapentin (Neurontin).

Decision rationale: According to the CA MTUS (2009) and the ODG, Neurontin (Gabapentin) is an anti-epilepsy drug (AED), which has been considered a first-line treatment for neuropathic pain. The records documented that the patient has neuropathic pain related to this patient's chronic back condition. The continued use of AEDs depends on improved outcomes versus tolerability of adverse effects. A "good" response to the use of AEDs has been defined as a 50% reduction in pain and a "moderate" response as a 30% reduction. In this case, there was documentation of 50% improvement (with 300 mg). Based on this improvement, however, there is an unclear physician request for an increase in dosage (to 600 mg #270 with 3 refills). The requested dosage increase in medication is not recommended and medical necessity has not been established. The requested medication is not medically necessary.

Fiorinal 50/325 40mg: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Fiorinal. Decision based on Non-MTUS Citation Guideline for primary care management of headache in adults. Edmonton (AB): Toward Optimized Practice; 2012 Jul. 71 p.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Barbiturate-containing analgesic agents (BCAs).

Decision rationale: Barbiturate-containing analgesic agents (BCAs) are not recommended for chronic pain. The potential for drug dependence is high and no evidence exists to show a clinically important enhancement of analgesic efficacy of BCAs due to the barbiturate constituents. Fiorinal 50/325/40 mg contains butalbital, aspirin and caffeine. The literature reported that butalbital containing combination analgesics should be avoided in migraine headache management. When used, it should be closely monitored to avoid overuse and dependence. It is recommended to be used less than 10 days/month. In this case, there is no documentation of the efficacy of this medication. Medical necessity for the requested item has not been established. The requested item is not medically necessary.

Lidocaine patch 5%: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical analgesics Page(s): 111-113.

Decision rationale: According to the California MTUS Guidelines (2009), topical analgesics, such as the Lidoderm 5% patch, are primarily recommended for neuropathic pain when trials of

antidepressants and anticonvulsants have failed. These agents are applied topically to painful areas with advantages that include lack of systemic side effects, absence of drug interactions, and no need to titrate. Many agents are compounded as monotherapy or in combination for pain control, for example, NSAIDs, opioids, or antidepressants. 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 (tri-cyclic 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 this case, medical necessity of the requested item has not been established. The certification of the requested Lidoderm patches is not recommended. Therefore the request is not medically necessary.

Zofran 8mg: 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), Pain (Chronic), Antiemetics (for opioid nausea).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Medscape Internal Medicine.

Decision rationale: Ondansetron (Zofran) is used to prevent nausea and vomiting that may be caused by anesthesia/surgery, or chemotherapy or radiation therapy. It is also approved for use acutely with gastroenteritis. Ondansetron is not used and is ineffective for nausea associated with narcotic analgesics. Medical necessity of the requested medication has not been established. The requested medication is not medically necessary.